

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 05112/8

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Derwood (rural)  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 wks  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montg  
 City or town Derwood (rural)  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Cecil R. Barnette

## 3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

single

6.(b) Name of husband or wife \_\_\_\_\_

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) March 6 1948

8. AGE: Years \_\_\_\_\_ Months 1 Days 25 If less than one day  
 \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Scott Co. Va  
 (Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Stallard Barnette13. Birthplace VA14. Maiden name Grace Johnson15. Birthplace VA16. Informant Stallard BarnetteAddress Derwood Md

17. Burial Date thereof 5-2-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Josbury CemeteryLocation Josbury Va18. Funeral director Quish B. FactoryAddress Fairhurst Rd.

19. May 1 1948 Alouda L. Cook  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1948 at 3:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19  
 and that I last saw him alive on home care 19

Immediate cause of death Heart - infarction

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

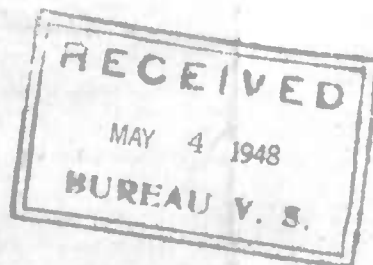
Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Frank J. Burchart M.D.Address Derwood Md Date signed 5-1-48

DURATION

Short  
death  
in bed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The present age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? died on arrival  
 Hospital, institution, or street address where death occurred:  
U. S. Naval Hosp - Bethesda Md  
 How long in hospital or institution? died on arrival

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montg  
 City or town Berwin  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 5030 Geronimo Road  
 (If rural, give LOCATION)  
 2(a) If veteran, name war WWI

## 3. (a) FULL NAME

Joseph Edward Bateman

## 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Mildred Bateman

7. Birth date of deceased (mo., day, yr.) October 12, 1894 6. (c) If alive, give age 54 years

8. AGE: Years 54 Months 2 Days 7 If less than one day hrs. min.

9. Birthplace Norfolk, Va.  
 (Town, county, and state)

10. Usual occupation Painter

11. Industry or business

12. Name BATEMAN, Joseph T.  
 13. Birthplace Va.

14. Maiden name HASSLIP, Carrie  
 15. Birthplace Va.

16. Informant wife: Mrs. Mildred Bateman  
 Address Berwin, Md.

17. burial Date thereof May 14, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Arlington National  
 Location Arlington, Va.

18. Funeral director W. W. CHAMBERS L.E.B.  
 Address Riverdale, Md.  
Mary C. Patterson

19. 5-12 19 48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 19 48 at 7:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Def med Exam case 19 to 19 and that I last saw h. alive on 19 19

Immediate cause of death Valvular Heart Disease  
Aortic Stenosis

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results Acute Pulmonary Edema  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Broschart M.D. M. D. or otherAddress Garthman Md Date signed 5-11-48

**RECEIVED**

MAY 13 1948

**BUREAU V. S.**



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05109

216

Reg. Dist. No. ....

### 1. PLACE OF DEATH:

County.....Montgomery.....

City or town.....Bethesda (rural).....  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....3 days.....

Hospital, institution, or street address where death occurred:  
U. S. NAVAL HOSPITAL, Bethesda, Md.

How long in hospital or institution?.....3 days.....

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Md...... County.....Montgomery.....

City or town.....Chevy Chase.....  
(If outside city or town limits, write RURAL and give nearest town)

Street No.....2725 Washington Avenue.....  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

### 3. (a) FULL NAME

BEHRENS, Charles William

### 3. (b) Social Security Number

4. Sex.....Male..... 5. Color or race.....W-US..... 6.(a) Single, married, widowed, or divorced.....widowed.....

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....May 5, 1861..... 6.(c) If alive, give age..... years

8. AGE: Years.....87..... Months.....0..... Days.....9..... If less than one day..... hrs. .... min.

9. Birthplace.....Germany.....  
(Town, county, and state)

10. Usual occupation.....unemployed.....

11. Industry or business.....

12. Name.....BEHRENS, John Jacob..... d.ec.

13. Birthplace.....Denmark.....

14. Maiden name.....SICK, ?..... d.ec.

15. Birthplace.....Denmark.....

16. Informant.....SON: Capt. Charles F. Behrens.....

Address.....2725 Washington Ave., Chevy Chase, Md......

17. burial..... Date thereof.....5-18-48.....  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....Mount Moriah.....

Location.....Philadelphia, Penn......

18. Funeral director.....Reuben Rumphrey.....

Address.....7557 Wisconsin Ave., Bethesda, Md......

19. 5-15.....48.....Mary G. Patterson.....  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH.....11 May..... 19..48.. at.....10:10P.. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....11 May..... 19..48.. to.....11 May..... 19..48..  
and that I last saw h.....im..... alive on.....11 May..... 19..48..

Immediate cause of death.....Coronary Heart Disease, Arteriosclerotic..... DURATION.....1 year.....  
Due to.....Generalized Arteriosclerosis.....5 years.....

Due to.....Congestive Heart Failure.....7 days.....  
Broncho Pneumonia.....2 days.....  
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....As above.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:  
Accident, suicide, or homicide..... Date of .....  
Where did injury occur?..... (City or town)..... (County)..... (State).....  
Injured at home, farm, industry, pub'c place (where?).....  
Means of injury..... Injured at work?.....

23. SIGNATURE.....T. E. JARRETT..... CDR MC USN or other.....  
Address.....USNH Bethesda, Md...... Date signed.....5-15-48.....

MARGIN RESERVED FOR BINDING

9-45-15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 18 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 month, 19 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 1 month, 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State D.C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1215 12th St., N.W.  
 (If rural, give LOCATION)  
 2(a) If veteran, name war WWI

## 3. (a) FULL NAME

BLAUSSER, Verne

## 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Margaret Blausser  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) January 19, 1897

8. AGE: Years 51 Months 4 Days 1 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Indiana  
 (Town, county, and state)

10. Usual occupation Government (Civil Service)

## 11. Industry or business

12. Name BLAUSSER, W. M. dec  
 13. Birthplace Ind.  
 14. Maiden name YEAGER, Melissa  
 15. Birthplace Va.

16. Informant Wife: Mrs. Margaret Blausser  
 Address 1215 12th St., N. W., Wash., D.C.

17. burial Date thereof 5-21-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National  
 Location Arlington, Va.

18. Funeral director W. W. Chambers M. K. Wade  
 Address 1400 Chapin St., N. W., Wash., D.C.

19. 5-20 48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 20 May 19 48, at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 April 19 48 to 20 May 19 48  
 and that I last saw him alive on 20 May 19 48

Immediate cause of death \_\_\_\_\_ DURATION 3 days

Due to Bronchopneumonia

Due to Hemochromatosis

Due to Hemochromatosis

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

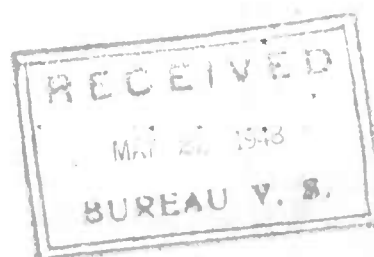
Injured at home, farm, industry, pub'c place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

Signature W. A. DINSMORE, Jr. LCDR MC USN

23. SIGNATURE \_\_\_\_\_ M. D. or other \_\_\_\_\_

Address USNH Bethesda, Md. Date signed 5-20-48



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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05111

Reg. Dist. No. 714

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Silver Spring  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 year  
 Hospital, institution, or street address where death occurred:  
Silver Spring Country Club  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State DC County  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 5427 4th St N.W.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Oscar Blumenthal

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Rose Blumenthal  
 7. Birth date of deceased (mo., day, yr.) June 7 1882  
 6.(c) If alive, give age..... years  
 8. AGE: Years 66 Months 11 Days 8 If less than one day  
 .... hrs. .... min.

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1948 at 12:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Deep med brain case to 19.....  
 and that I last saw him alive on 19.....  
 Immediate cause of death Coronary occlusion

## DURATION

Due to.....  
 Due to.....  
 Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings of operations.....  
 Date of op. ....  
 Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Frank J. Bronckhorst M.D.  
Deep med brain case M. D. or other  
 Address Washington Date signed 5-15-48

9. Birthplace Germany  
 (Town, county and state)  
 10. Usual occupation Office manager  
(retired)  
 11. Industry or business  
 12. Name Levi Blumenthal  
 13. Birthplace Germany  
 14. Maiden name unknown  
 15. Birthplace  
 16. Informant Albert Blumenthal  
 Address 1432 18th St. NW DC  
 17. Buried Date thereof May 18-1948  
 (Burial, cremation, or other disposal. Which?) (month) (day) (year)  
 Cemetery or crematory Snodgrass, Quaker  
 Location Oxon Hill Md  
Goldberg Funeral Home  
 18. Funeral director  
 Address 4417-4th St NW Wash DC  
 19. May 15 1948 Registrar Joseph W. Schaeffer  
 (Date rec'd by registrar)

RECEIVED

MAY 19 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05112

Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County MontgomeryCity or town 2 James Park  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

123 Anne Street

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County MontgomeryCity or town James Park  
(If outside city or town limits, write RURAL and give nearest town)Street No. 123 Anne Street  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

JOHN DOUGLAS BRADSHAW, Jr.

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 9, 1942

## 8. AGE: Years Months Days If less than one day

6 3 15 hrs. min.9. Birthplace Washington, D.C.  
(Town, county, and state)10. Usual occupation Student11. Industry or business At Home12. Name J. Douglas Bradshaw13. Birthplace Stafford, Virginia14. Maiden name Alena White15. Birthplace Washington, D.C.16. Informant J. Douglas BradshawAddress 123 Anne Street, James Park, Md.17. Burial Date thereof May 24, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rock Creek CemeteryLocation Webster St + Rock Creek Ch. Rd., Washington, D.C.18. Funeral director J. Arthur WaltersAddress 254 Carroll St. N.W., James Park, D.C.19. May 21, 1948 Registrar John D. Smith  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 21, 1948 at 3:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1948 and that I last saw him alive on May 21, 1948

Immediate cause of death

Measles  
Bacterial pneumonia

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John D. Smith M. D. or otherAddress James Park, Md. Date signed 5/21/48

## DURATION

3 days? founddead in bed





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05113

Reg. Dist. No.

216

## 1. PLACE OF DEATH:

County... Montgomery  
 City or town... Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 8 months  
 Hospital, institution, or street address where death occurred:  
Suburban Hospital  
 How long in hospital or institution? 4 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Montgomery  
 City or town... Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 5202 Roosevelt St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Cyril Oliver Bratley

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Eleanor Bratley

## 7. Birth date of deceased (mo., day, yr.)

September 1, 1903

## 6. (c) If alive, give age..... years

## 8. AGE:

Years

Months

Days

If less than one day

4488

hrs.

min.

## 9. Birthplace

Wichita Kansas  
(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

U.S. Dept. of Agriculture

MOTHER FATHER

## 12. Name

Jesse H. Bratley

## 13. Birthplace

Wisconsin

## 14. Maiden name

Della Ranson

## 15. Birthplace

Illinois

## 16. Informant

Mrs. Eleanor Bratley

## Address

5202 Roosevelt St., Bethesda

## 17.

Burial

(Burial, cremation, or removal: Which?)

## Date thereof

May 11, 1948

(month) (day) (year)

## Cemetery or crematory

Ft. Lincoln Cem.

## Location

3201 Bladensburg Rd.

## 18. Funeral director

S.D. Flinn Co.

## Address

2901 14th NW.

## 19.

5/9  
(Date rec'd by registrar)1948W E Jones

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 1948 at 4:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 9 1948 to May 9 1948  
and that I last saw him alive on May 9 1948Immediate cause of death Pulmonary  
Edema & Cardiac

## DURATION

Due to Hypertensive Heart  
DiseaseDue to Rheumatic Heart Disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results Done on above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury

Injured at work?

23. SIGNATURE

W E Jones  
549 14th NW  
Bethesda, Md.  
Address..... Date signed 5-9-48

RECEIVED

MAY 12 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

93d

05114

Reg. Diat. No. 217

1. PLACE OF DEATH: Montgomery  
 County.....  
 City or town.....Olney  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....  
 Hospital, institution, or street address where death occurred:  
 .....  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State.....Maryland..... County.....Montgomery  
 City or town.....Olney  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....Old Baltimore Rd.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3.(a) FULL NAME  
Idelma Bronson

3.(b) Social Security Number

4. Sex.....Female  
 5. Color or race.....White  
 6.(a) Single, married, widowed, or divorced.....Widowed

6.(b) Name of husband or wife.....Walter G. Bronson

7. Birth date of deceased (mo., day, yr.).....May 8, 1855  
 6.(c) If alive, give age..... years

8. AGE: Years.....93 Months.....0 Days.....5  
 If less than one day..... hrs. .... min.

9. Birthplace.....Lisle, New York  
 (Town, county, and state)

10. Usual occupation.....Retired

11. Industry or business.....

12. Name.....Frank Fenner

13. Birthplace.....Bristol, R. I.

14. Maiden name.....Mary Brooks

15. Birthplace.....New York State

16. Informant.....Mrs Robert F. Melne

Address.....Olney, Maryland.

17. Burial Date thereof.....May 15, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....Floral Park

Location.....Johnson City, New York

18. Funeral director.....Warner E. Humphrey, Inc.

Address.....8434 Ga. Ave. Silver Spring, Md.

19. 5-15-48 Bertrude B. Lawler  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....5/13/48..... at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/1/48 to 5/12/48 and that I last saw him alive on 5/4/48 1948

Immediate cause of death.....Chronic Myocarditis  
Hypertension DURATION.....4 mos

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

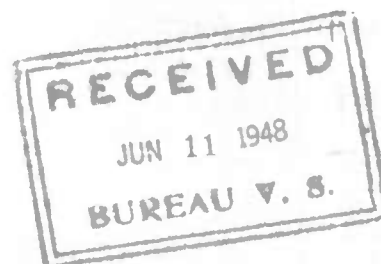
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....Sanby Sp... M. D. or other

Address..... Date signed.....5/13/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The (color) age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

05115

216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Chevy Chase  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 26 years  
 Hospital, institution, or street address where death occurred:  
6412 Ridgewood Avenue,  
 How long in hospital or institution? None

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Chevy Chase  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 6412 Ridgewood Avenue,  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war None

## 3. (a) FULL NAME

Claire Brown

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Harry J. Brown  
 6. (c) If alive, give age 70 years  
 7. Birth date of deceased (mo., day, yr.) February 11, 1875  
 8. AGE: Years Months Days If less than one day  
73 73 3 12 ..... hrs. .... min.

9. Birthplace Baltimore, Maryland  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business None

12. Name J. Arthur Rigby  
 13. Birthplace Baltimore, Maryland  
 14. Maiden name Zoe Bunting  
 15. Birthplace Maryland

16. Informant Mr. Brown  
 Address Chevy Chase, Maryland

17. Cremation Date thereof May 25, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Cedar Hill Crematory  
 Location Prince George County

18. Funeral director W. Pauline Humphrey  
 Address Bethesda, Maryland

19. 5/26/48 19 48 Wm E Jones  
 (Date rec'd by registrar) Reg. Seal

## MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 23 19 48 at 8:50 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ? 19 42 to MAY 22 19 48  
 and that I last saw him ER alive on MAY 22 19 48

Immediate cause of death BRONCHIO PNEUMONIA  
LEFT LUNG, Both Lobes  
 DURATION 4 DAYS

Due to .....

Due to .....

Other conditions PARKINSONS DISEASE 6 yrs.?

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Dr. W. E. Jones, M.D. M. D. or other

4828 Chevy Chase Dr  
Chevy Chase, Md Address..... Date signed 5-23-48

RECEIVED

JUN 2 1948

BUREAU V. S.

4EVS dd

20. SIGNATURE 1007-1 54 1-11 M. D. or other 5/3/10

VS A15. 9-45:15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**MOTHER FATHER**

RECEIVED

MAY 6 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 6 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County PG.  
 City or town College Park  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 7303 Yale Avenue  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war WWI

## 3. (a) FULL NAME

CAMERON, Stephen Francis

## 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Amie Cameron  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) June 26, 1898  
 8. AGE: Years 49 Months 10 Days 14 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Md.  
 (Town, county, and state)  
 10. Usual occupation Civil Service  
Internal Revenue  
 11. Industry or business  
 12. Name CAMERON, Clarence dec  
 13. Birthplace Rt. Md.  
 14. Maiden name MacElwee, Rose dec.  
 15. Birthplace Pa.

16. Informant wife: Mrs. Amie Cameron  
 Address 7303 Yale Ave., College Park, Md.  
 17. burial Date thereof 5-13-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Arlington National  
 Location Arlington, Va.  
 18. Funeral director S. H. HINES JZR  
 Address 2901 14th St., N.W., Wash. D.C.  
Mary C. Patterson  
 19. 5-10 19-48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 10 May 19 48 at 7:20 A.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4 May 19 48 to 10 May 19 48  
 and that I last saw him alive on 10 May 19 48

Immediate cause of death  
Thrombosis, Coronary Artery

DURATION  
10 hrs.

Due to Arteriosclerosis, Generalized Indef.

Due to Diabetes, Mellitus Indef.

Due to Nephrosclerosis Indef.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work \_\_\_\_\_

23. SIGNATURE W. A. DINSMORE, Jr., LCDR MC USN

M. D. or other

Address USNH Bethesda, Md. Date signed 5-10-48

RECEIVED

MAY 13 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The total age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

47C \*

05118

216

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Montgomery  
Bethesda (rural)  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 22 days  
 Hospital, institution, or street address where death occurred:  
U. S. NAVAL HOSPITAL, Bethesda, Md.  
 How long in hospital or institution? 22 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington, D. C. County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 618 A St., S.E.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war WWII

## 3. (a) FULL NAME

CARSON, Eugene Joseph

## 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Mrs. Martha E. Carson  
 7. Birth date of deceased (mo., day, yr.) September 9, 1903  
 6. (c) If alive, give age..... years  
 8. AGE: Years Months Days If less than one day  
44 7 27 ..... hrs. .... min.

9. Birthplace Mass.  
 (Town, county, and state)  
 10. Usual occupation Guard  
Library Congress  
 11. Industry or business  
 12. Name CARSON, Eugene  
 13. Birthplace Mass.  
 14. Maiden name MORINE, Corine  
 15. Birthplace ?

16. Informant wife: Mrs. Martha E. Carson  
 Address 618 A St., S. E., Washington, D. C.  
 17. burial Date thereof 5-10-48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Arlington National  
Arlington, Va.  
 Location  
 18. Funeral director W. W. CHAMBERS  
 Address 517 11th St., S.E., Washington, D. C.  
5-6 48  
 (Data rec'd by registrar) 18 48  
Mary C. Patterson  
 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 6 May 19 48 at 3:54A M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 14 April 19 48 to 6 May 19 48  
 and that I last saw him alive on 6 May 19 48  
 Immediate cause of death Adenocarcinoma, bronchogenic  
 DURATION  
 Due to.....  
 Due to.....  
 Other conditions Postoperative shock  
 (Include pregnancy within 3 months of death)  
 Major findings of operations Adenocarcinoma, bronchogenic  
 Date of op. 4-30-48  
 Autopsy results confirmed above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injury at work?  
 23. SIGNATURE R. N. SHELLEY, Cdr. MC USN  
 M.D. or other  
 Address USNH Bethesda, Md. Date signed.....

RECEIVED

MAY 10 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 197

## 1. PLACE OF DEATH:

County MontgomeryCity or town Clarksville Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Montg Co Gen Hos Bldg

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HowardCity or town Clarksville  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Richard C Chambers

## 3. (b) Social Security Number

## 4. Sex

M

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

Widower

## 6. (b) Name of husband or wife

Margie Lou Chambers

8. (c) If alive, give age \_\_\_\_\_ years

## 7. Birth date of

deceased (mo., day, yr.)

Nov. 5, 1877

## 8. AGE:

Years

70

Months

6

Days

24

If less than one day

hrs.

min.

## 9. Birthplace

Maryland  
(Town, county, and state)

## 10. Usual occupation

None

## 11. Industry or business

## FATHER

## 12. Name

William Chambers

## 13. Birthplace

Md.

## MOTHER

## 14. Maiden name

Catherine Blakey

## 15. Birthplace

Md.

## 16. Informant

## Address

Hospital Records  
Clarksville Md

## 17. Burial

(Burial, cremation, or removal) Which?

Date thereof

6-1-48  
(month) (day) (year)

## Cemetery or crematory

St Louis

## Location

Clarksville Md.

## 18. Funeral director

## Address

F.C. Hagenbock  
Clarksville City Md

## 19. Date

May 30, 1948  
(Date rec'd by registrar)

19. 48

John B. Loughran  
Reg. Dist. 2

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

May 29, 1948, at 3:00 P.M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 17, 1946, to May 29, 1948

and that I last saw him alive on

May 29, 1948

## Immediate cause of death

## DURATION

Septicemia5 days

Due to

pyelonephritis5 days

Due to

Other conditions arteriosclerotic heart disease2 yrs.

(Include pregnancy within 3 months of death)

## Major findings of operations

Benign prostatic hyper-  
trophyDate of op. 5-13-48

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

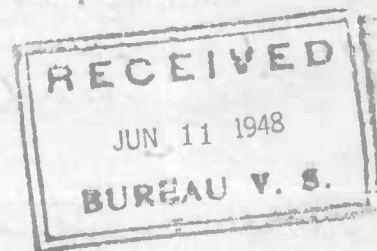
## 23. SIGNATURE

Charles S. Whitaker M.D.

M. D. or other

Address

Clarksville, Md.Date signed 5-30-48



Dr's letter  
BIRTHDATE: Dr's letter  
filmed G116 6-9-48 L

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County Montgomery  
City or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
City or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 9702 Monroe St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

George V. Chandler

3.(b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Caroline W.

7. Birth date of deceased (mo., day, yr.) October 31, 1866 6.(c) If alive, give age years

8. AGE: Years 81 Months 6 Days 20 If less than one day hrs. min.

9. Birthplace Washington, D.C.  
(Town, county, and state)

10. Usual occupation U. S. Patent Office

11. Industry or business

12. Name Malcolm Chandler

13. Birthplace Canada

14. Maiden name Sarah E. Harding

15. Birthplace Mass.

16. Informant Mrs Caroline W. Chandler

Address 9702 Monroe St.

17. Cremation Date thereof May 14, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Suitland, Prince George Co. Md

18. Funeral director Warner E. Humphrey, Inc.

Address 8434 Ga. Ave., Silver Spring, Md.

19. May 12 1948 Josephine Schaeff  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11, 1948 at 8:00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1943 to May 11, 1948  
and that I last saw him alive on May 11, 1948

Immediate cause of death Congestive Heart Failure DURATION 2 weeks

Due to Chronic Myocarditis Ten years

Due to

Other conditions Arteriosclerosis 5 years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. H. Howlett M.D. M.D. or other

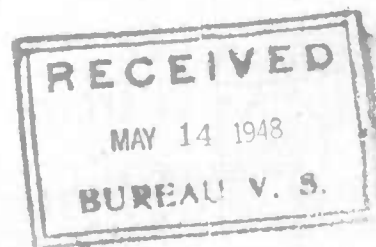
Address 228 Sigo Ave, Silver Spring, Md. Date signed May 12, 1948

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.







RECEIVED

MAY 13 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

30d

05122 218

Reg. Dist. No. ....

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 6 days  
Hospital, institution, or street address where death occurred:  
**U. S. NAVAL HOSPITAL, Bethesda, Md.**  
How long in hospital or institution? 6 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington, D. C. County .....  
City or town .....  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1145 6th St., N. E.  
(If rural, give LOCATION)  
2. (a) If veteran, name war WWI ✓

### 3. (a) FULL NAME

COATES, Charles Nathaniel

### 3. (b) Social Security Number

4. Sex Male 5. Color or race Col US 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife .....

7. Birth date of deceased (mo., day, yr.) March 8, 1897 5. (c) If alive, give age ..... years

8. AGE: Years 51 Months 2 Days 6 If less than one day ..... hrs. .... min.

9. Birthplace Washington, D. C.  
(Town, county, and state)

10. Usual occupation unemployed

11. Industry or business .....

12. Name COATES, James dec.

13. Birthplace Md.

14. Maiden name DERICK, Rebecca dec.

15. Birthplace Va.

16. Informant Aunt: Mrs. Henrietta Boom

Address 1145 6th St., N.E., Washington, D. C.

17. burial Date thereof 5-18-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington, Va.

18. Funeral director McGuire Funeral Home John

Address 1820 9th St., N. W., Washington, D. C.

19. 5-14 48 Mary C. Patterson  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 19 48, at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8 May 19 48 to 14 May 19 48

and that I last saw him alive on 14 May 19 48

Immediate cause of death Rupture non-traumatic aortic aneurysm DURATION

Due to Aortic aneurysm 1yr +

Due to Syphilitic Positive Serology 31

Other conditions 6/28/48 U.S.

(Include pregnancy within 8 months of death)

Major findings of operations .....

Antopsy results Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?),

Means of injury DEB injured at work?

Signature E. BILLMAN, Lt JG MC USN

Address USNH Bethesda, Md. Date signed 5-14-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05123

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 month, 3 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 1 month, 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State D.C. County \_\_\_\_\_  
Washington  
 City or town \_\_\_\_\_  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 4960 Eads Place, N. E.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war WW I ✓

## 3.(a) FULL NAME

COLEMAN, James Robert

## 3.(b) Social Security Number

4. Sex male 5. Color or race Col. 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Willie Mae Coleman  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) June 16, 1899  
 8. AGE: Years 48 Months 11 Days 17 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

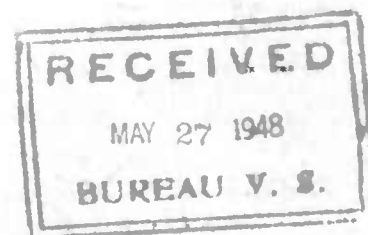
9. Birthplace N.C.  
 (Town, county, and state)  
 10. Usual occupation Chauffeur messenger  
 11. Industry or business \_\_\_\_\_  
 12. Name COLEMAN, King David dec. \_\_\_\_\_  
 13. Birthplace S.C.  
 14. Maiden name JACKSON, Luthenda dec. \_\_\_\_\_  
 15. Birthplace S.C.

16. Informant wife: Mrs. Willie Mae Coleman  
 Address 4960 Eads Pl., N.E., Wash., D.C.  
 17. burial Date thereof 5-27-48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Arlington National  
 Location Arlington, Va.  
 18. Funeral director W. Ernest Jarvis  
 Address 1432 U St., N. W., Wash., D.C.  
 19. 5-24- 48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 23 May 19 48 at 1 A. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 20 April 19 48 to 23 May 19 48  
 and that I last saw him alive on 23 May 19 48  
 Immediate cause of death Nephritis, chronic Indef  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions Hypertension, Arterial Indef  
 (Include pregnancy within 3 months of death)  
 Major findings of operations \_\_\_\_\_  
 Date of op. \_\_\_\_\_  
 Autopsy results confirmed above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE L. E. Watters  
L. E. WATTERS, Jr., Lt. JG MC USN  
 M. D. or other \_\_\_\_\_  
 Address USNH Bethesda, Md. Date signed 5-24-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

164 C

05124  
216

Reg. Dist. No. ....

1. PLACE OF DEATH: Montgomery  
County.....  
City or town..... Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... 1 month, 13 days  
Hospital, institution, or street address where death occurred:  
U. S. NAVAL HOSPITAL, Bethesda, Md.  
How long in hospital or institution?..... 1 month, 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... Michigan County.....  
City or town..... Detroit  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1524 Rose Lawn  
(If rural, give LOCATION)  
2.(a) If veteran, name war..... WW IIA 32 ✓

3.(a) FULL NAME  
CONNELLY, James Hoban

3.(b) Social Security Number

4. Sex Male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced  
married

6.(b) Name of husband or wife..... Mrs. Ester Connelly

7. Birth date of deceased (mo., day, yr.) December 30, 1904 6.(c) If alive, give age..... years

8. AGE: Years 43 Months 4 Days 13 If less than one day  
..... hrs. .... min.

9. Birthplace..... Michigan  
(Town, county, and state)

10. Usual occupation..... Retired Naval Dental Officer

11. Industry or business .....

12. Name..... CONNELLY, Lawrence dec.

13. Birthplace..... Michigan

14. Maiden name..... HEALY, Teresa dec.

15. Birthplace..... Canada

16. Informant..... wife: Mrs. Ester Connelly

Address..... 1524 Rose Lawn, Detroit, Michigan

17. burial Date thereof..... 5-18-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Arlington National

Location..... Arlington, Virginia

18. Funeral director..... W. W. Chambers Co. A.P.

Address..... 1400 Chapin St., NW, Wash., D.C.

19. 5-16 48 Mary C. Patterson  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 13 1948, at 7 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Dep med Exam case 19..... to..... 19.....  
and that I last saw h..... alive on..... 19.....

Immediate cause of death.....

Bullet wound in skull DURATION  
instantly

Due to.....

Due to.....

Other conditions..... meningeal inflammation  
Pneumonia  
(Include pregnancy within 3 months of death) 4 yrs.

Major findings of operations.....

..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... suicide Date of 5-13-48

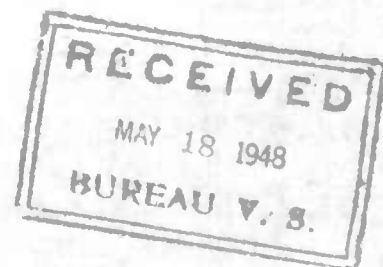
Where did injury occur?..... Bethesda Monte Md  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... 22 cal pistol Injured at work?

23. SIGNATURE..... Frank J. Brockett M.D.  
Dep med Exam M. D. or other

Address..... Washington Md Date signed..... 5-13-48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

## 1. PLACE OF DEATH:

County... MONTGOMERY  
 City or town... OLNEY  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?... 35 days  
 Hospital, institution, or street address where death occurred:  
Montgomery Co. General Hospital  
 How long in hospital or institution?... 35 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Maryland County... Montgomery  
 City or town... Rockville RT #1  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. ....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war .....

## 3. (a) FULL NAME

WILLIE CONNELLY

## 3. (b) Social Security Number

4. Sex... F 5. Color or race... Wh 6.(a) Single, married, widowed, or divorced... Married  
 6.(b) Name of husband or wife... WALLACE CONNELLY  
 6.(c) If alive, give age... 52 years  
 7. Birth date of deceased (mo., day, yr.)... September 19, 1895  
 8. AGE: Years... 52 Months... 8 Days... 0 If less than one day... — hrs. — min.

9. Birthplace... GAITHERSBURG MONTGOMERY MARYLAND  
 (Town, county, and state)10. Usual occupation... HOUSEWIFE

## 11. Industry or business

12. Name... John Mill  
 13. Birthplace... Travilah, Maryland  
 14. Maiden name... Lida Ward  
 15. Birthplace... Gaithersburg Maryland

16. Informant... Patricia & Wallace Connelly  
 Address... Rockville #1, Maryland

17. Burial... Burial Date thereof... May 21, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... GreenwoodLocation... Montgomery County, Md.18. Funeral director... Wm. H. ThompsonAddress... Bethesda Md

19. May 18, 1948 Gettysburg Park  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... May 18, 1948 at... 1:12 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
April 13, 1948 to May 18, 1948  
 and that I last saw him alive on May 18, 1948

Immediate cause of death... Intestinal Obstruction  
 DURATION... 22 days

Due to... Distended Pyloric Stomach  
Cholelithiasis  
 Due to... Duodenal ulcer  
 ? Months  
 ? Hours

Other conditions... Posterior Gastro-enterostomy  
Jejunostomy  
 (Include pregnancy within 3 months of death)  
 DURATION... 22 days  
1 day

Major findings of operations... Pyloric stenosis due to  
old duodenal ulcer Date of op. 4-27-48

Autopsy results... —  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

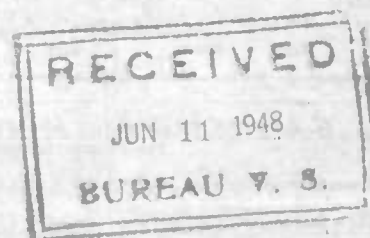
## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... — Date of... —

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury... — Injured at work? —23. SIGNATURE... J. B. ... M. D. or otherAddress... Sandy Spring Md Date signed... 3/10/48



Evidence for change of age and birth date: shown on: MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05126

216

U.S. No. G. 116 MAY 27 1948 CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH: Montgomery  
County.....  
City or town..... Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 17 days  
Hospital, institution, or street address where death occurred:  
U. S. NAVAL HOSPITAL, Bethesda, Md.  
How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Washington, D. C. County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1310 S St., S.E.  
(If rural, give LOCATION)  
2(a) If veteran, name war..... WWI

3. (a) FULL NAME

CORCORAN, William Joseph

3. (b) Social Security Number

4. Sex Male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married  
6. (b) Name of husband or wife Ruby Corcoran  
7. Birth date of deceased (mo., day, yr.) March 18, 1890 1880  
8. AGE: Years 68 58 Months 1 Days 19 If less than one day hrs. min.

9. Birthplace Penna.  
(Town, county, and state)  
10. Usual occupation unknown  
11. Industry or business

12. Name CORCORAN, Peter dec.  
13. Birthplace Scotland  
14. Maiden name WELSH, Mary dec.  
15. Birthplace Scotland

16. Informant wife: Mrs. Ruby Corcoran  
Address 1310 S., St., S.E., Washington, D. C.

17. burial Date thereof 5-11-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Arlington National  
Location Arlington, Virginia

18. Funeral director Simon's Brothers Funeral Home  
Address 2007 Nichols Ave., S.E., Wash. D.C. 448

19. 5-7-1948 Mary C. Patterson  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 April 1948 at 9:15 Pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 20 April 1948 to 7 May 1948  
and that I last saw him alive on 7 May 1948

Immediate cause of death Hypertensive cardiac  
vascular disease. I measure cerebral  
infarct  
Due to Hypertension

Due to  
Other conditions none

(Include pregnancy within 3 months of death)  
Major findings of operations Normal brain on bilateral  
temporal lobectomy Date of op. 5/6/48  
Autopsy results Confirmed above  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE W. J. JAMES, Cdr. MC USN  
USNH Bethesda, Md.  
Date signed 5-7-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

61-1-19  
1948-4-4  
1880-3-18  
1948-8-16

RECEIVED  
MAY 11 1948  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05127

Reg. Dist. No. 214

## 1. PLACE OF DEATH:

County MontgomeryCity or town Silver Spring, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

8716 - Georgia Ave

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)Street No. 8716 - Georgia Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

JOHN W. COTTER.

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Catherine C. Fealy7. Birth date of deceased (mo., day, yr.) 1867 8. (c) If alive, give age..... years8. AGE: Years 81 Months..... Days..... If less than one day..... hrs. .... min.9. Birthplace Bellefontaine Ohio  
(Town, county, and state)10. Usual occupation Retired11. Industry or business Post office12. Name William Cotter13. Birthplace Bellefontaine Ohio14. Maiden name Margaret Mulvihill15. Birthplace Unknown16. Informant Certificate of Baptism

Address

17. Burial Date thereof 5/8/48  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Mt. Olivet CemeteryLocation Washington D.C.18. Funeral director Geothey Hanlon Funeral HomeAddress 641-14 St N.E. Wash. D.C.19. May 6 19 48 Josephine Schaeffe  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 5, 1948, at 8:35 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 4, 1948, to May 5, 1948, and that I last saw him alive on May 5, 1948.Immediate cause of death Chronic myocarditis

DURATION

6 mos.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE J. A. Connor M.D. M. D. or otherAddress 2026-16 St N.E. Wash. D.C. Date signed 5/5/48  
Washington, D.C.

RECEIVED

MAY 8 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1246

05128

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Takoma Park, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 year 4 months 7 days  
 Hospital, institution, or street address where death occurred:  
Washington Sanitarium & Hospital  
 How long in hospital or institution? 1 year 4 months 7 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington D.C. County Washington D.C.  
 City or town Washington D.C.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Kennedy Warren Apt  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war ✓

## 3. (a) FULL NAME

Mrs Emma Leckie Cox

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow  
 6.(b) Name of husband or wife Widow  
 7. Birth date of deceased (mo., day, yr.) October 18 - 1881 6.(c) If alive, give age 66 years  
 8. AGE: Years 66 Months 9 Days — If less than one day — hrs. — min.

9. Birthplace Shenandoah, Penna.  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business

12. Name Samuel Leckie  
 13. Birthplace Scotland  
 14. Maiden name Katharine McEllen  
 15. Birthplace Scotland

16. Informant Sanitarium Records  
 Address Takoma Park, Maryland  
 17. Reburial Date thereof 5/20/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Indefinite  
 Location Washington D.C.  
 18. Funeral director W.H. Jones Co  
 Address 2901-14 St. N.W.

19. May 18 1948  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1948 at 1:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 11 1948 to May 18 1948  
 and that I last saw him alive on May 17 1948

Immediate cause of death Congestive Cardiac Failure DURATION Terminal

Due to Cirrhosis of the Liver Due first to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results X  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) (City or town) (County) (State)

Means of injury Injured at work?

23. SIGNATURE Robert A. Hare MD. M. D. or other

Address Takoma Park, Md. Date signed 5/18/48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 218

<b>1. PLACE OF DEATH:</b> Montgomery County..... City or town..... Bethesda (rural) (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? 7 days Hospital, institution, or street address where death occurred: U. S. NAVAL HOSPITAL, Bethesda, Md. How long in hospital or institution? 7 days				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State Washington, D. C. County..... City or town..... (If outside city or town limits, write RURAL and give nearest town) Street No. 19 K St., N. W. (If rural, give LOCATION) 2.(a) If veteran, name war..... WWI			
<b>3. (a) FULL NAME</b> CURRIN, Crawford				<b>3. (b) Social Security Number</b>			
<b>4. Sex</b> male W-US		<b>5. Color or race</b> W-US		<b>6. (a) Single, married, widowed, or divorced</b> married			
<b>6. (b) Name of husband or wife</b> Mary Currin				<b>6. (c) If alive, give age</b> ..... years			
<b>7. Birth date of deceased (mo., day, yr.)</b> September 11, 1890				<b>8. AGE:</b> Years 57 Months 7 Days 15 If less than one day..... hrs. .... min.			
<b>9. Birthplace</b> N.C. (Town, county, and state)				<b>10. Usual occupation</b> Brakeman			
<b>11. Industry or business</b> Washington Terminal Railroad				<b>12. Name</b> CURRIN, John dec			
<b>13. Birthplace</b> N.C.				<b>14. Maiden name</b> HOWARD, Mary Frances dec			
<b>15. Birthplace</b> N.C.				<b>16. Informant</b> wife: Mrs. Mary Currin			
<b>Address</b> 19 K St., N. W., Washington, D. C.				<b>17. burial</b> Date thereof 5-12-48 (Burial, cremation, or removal. Which?) (month) (day) (year)			
<b>Cemetery or crematory</b> Arlington National				<b>Location</b> Arlington, Virginia			
<b>18. Funeral director</b> W. W. CHAMBERS P. J. K.				<b>Address</b> 517 11th St., S. E., Washington, D. C.			
<b>19. 5-9 1948</b> Mary D. Patterson				<b>20. DATE OF DEATH</b> 9 May 1948 5:51 A. M.			
<b>21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 May 1948 to 9 May 1948 and that I last saw him alive on 9 May 1948</b>							
<b>Immediate cause of death</b> pulmonary embolism (clinging)							
<b>Due to</b> Hypertensive heart disease							
<b>Due to</b>							
<b>Other conditions</b>							
(Include pregnancy within 8 months of death)							
<b>Major findings of operations</b> ..... Date of op. ....							
<b>Autopsy results</b> not obtained							
<b>PHYSICIAN: Please underline the cause to which death should be charged statistically.</b>							
<b>22. VIOLENCE: If death was due to external causes, fill in the following:</b>							
Accident, suicide, or homicide..... Date of .....							
Where did injury occur?..... (City or town)..... (County)..... (State).....							
Injured at home, farm, industry, public place (where?).....							
Means of injury..... Injured at work?.....							
<b>23. SIGNATURE</b> F. E. WEDEL, Lt MC USN							
Address USNH Bethesda, Md. Date signed 5-9-48							

Registrar

RECEIVED

MAY 11 1948 •

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

05130

216

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH: Montgomery  
County Bethesda (rural)  
City or town (If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 17 days  
Hospital, institution, or street address where death occurred:  
U. S. NAVAL HOSPITAL, Bethesda, Md.  
How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Washington, D. C. County .....  
City or town (If outside city or town limits, write RURAL and give nearest town)  
Street No. 1610 U St., N. W.  
(If rural, give LOCATION)  
2(a) If veteran, name war WWI ✓

3. (a) FULL NAME DARBY, Andrew

3. (b) Social Security Number

4. Sex male 5. Color or race Col, US 6. (a) Single, married, widowed, or divorced married  
6. (b) Name of husband or wife Beatrice Darby  
7. Birth date of deceased (mo., day, yr.) April 25, 1897 6. (c) If alive, give age ..... years  
8. AGE: Years 51 Months 0 Days 12 If less than one day ..... hrs. ..... min.

9. Birthplace Virginia  
(Town, county, and state)  
10. Usual occupation Cook  
11. Industry or business .....  
12. Name DARBY, James  
13. Birthplace Va.  
14. Maiden name ADKINS, Mary  
15. Birthplace Va.

16. Informant wife: Mrs. Beatrice Darby  
Address 1610 U St., N. W. Washington, D. C.  
17. burial Date thereof May 11, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Mt. Zion  
Location Downings, Virginia  
18. Funeral director Melvin & Shboy  
Address 424 R St., N. W., Wash., D. C.  
19. 5-7 48 Mary G. Patterson  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 7 May 19 48 at 12:01 P  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 20 April 19 48 to 7 May 19 48  
and that I last saw him alive on 7 May 19 48  
Immediate cause of death Nephritis, Chronic DURATION indef.  
Due to .....  
Due to .....  
Other conditions Hypertension arterial, indef  
terminal anemia with pericarditis 3 wks  
(Include pregnancy within 3 months of death)  
Major findings of operations ..... Date of op. .....  
Autopsy results not obtained  
PHYSICIAN: Please underline the cause to which death should be charged statistically.  
22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide ..... Date of .....  
Where did injury occur? ..... (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?) .....  
Means of injury F. E. WETZEL Injured at work? .....  
23. SIGNATURE F. E. WETZEL, Lt. MC USN M. D. or other .....  
USNH Bethesda, Md. Date signed 5-7-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**

MAY 11 1948

**BUREAU V. S.**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 218

## 1. PLACE OF DEATH

County MontgomeryCity or town Rural Gaithersburg md  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 1/2 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

John H Day4. Sex Male5. Color or race White6. (a) Single, married, widowed, or divorced divorced

6. (b) Name of husband or wife:

7. Birth date of deceased (mo., day, yr.) May 23 - 18758. AGE: Years 70 Months 0 Days 1 If less than one day

hrs. min.

9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Farming12. Name Lawson Day13. Birthplace Maryland14. Maiden name Elizabeth Nichols15. Birthplace Maryland16. Informant husband's motherAddress Gaithersburg md17. Burial Date thereof May 26 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or cremation Goshen rdLocation Montgomery Co md18. Funeral director Ray W BarberAddress Rockville md19. May 25 1948 Abraham J. Cooke  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Rural Gaithersburg md  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 19 48 at 9:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1942 19 48 to May 24 19 48and that I last saw him alive on May 22 19 48

Immediate cause of death \_\_\_\_\_

DURATION

Carcinoma of stomach,Due to with metastasis 1 year

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. \_\_\_\_\_

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

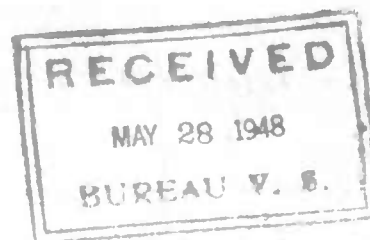
Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE J. P. Lenthien, M.D.Address Rockville, md Date signed 7/24/48

M.D. or other



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 05132 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 21 days  
 Hospital, institution, or street address where death occurred:  
U. S. NAVAL HOSPITAL, Bethesda, Md.  
 How long in hospital or institution? 21 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Washington, D. C. County ...  
 City or town ...  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 5618 New Hampshire Avenue, N. E.  
 (If rural, give LOCATION)  
 2(a) If veteran, name war WWI

## 3. (a) FULL NAME

DE LA VERGNE, Asa Ward

## 3. (b) Social Security Number

4. Sex Male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Isabella De La Vergne  
 6. (c) If alive, give age ... years  
 7. Birth date of deceased (mo., day, yr.) January 15, 1883  
 8. AGE: Years 65 Months 3 Days 25 If less than one day ... hrs. ... min.

9. Birthplace Washington, D.C.  
 (Town, county, and state)  
 10. Usual occupation Lithographer  
 11. Industry or business Weather Bureau, Wash., D.C.  
 12. Name DE LA VERGNE, Nathan dec.  
 13. Birthplace Md.  
 14. Maiden name THOMSON, Claudine dec.  
 15. Birthplace Washington, D. C.

16. Informant wife: Mrs. Isabella De La Verne  
 Address 5618 New Hampshire Ave, Washington, D. C.  
 17. burial Date thereof 5-13-48  
 (Burial, cremation, or removal. Which) (month) (day) (year)  
 Cemetery or crematory Glenwood  
 Location Washington, D. C.  
 18. Funeral director S. H. Hines  
 Address 2901 14th St., NW, Wash., D.C.  
Mary C. Patterson  
 19. 5-10 48 19  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 10 May 19 48 at 3:47 P.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 April 19 48 to 10 May 19 48  
 and that I last saw him alive on 10 May 19 48  
 Immediate cause of death Carcinoma, metastatic, generalized DURATION 4 months  
 Due to Primary site unknown  
 Due to ...  
 Other conditions Biphas 4/8/48 at Georgetown  
Unir. lung reported as "diaplasia"  
adenocarcinoma  
 (Include pregnancy within 3 months of death)  
 Major findings of operations ... Date of op. ...  
 Autopsy results not obtained  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide ... Date of ...  
 Where did injury occur? ... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) ...  
 Means of injury ... Injured at work? ...  
 23. SIGNATURE H. R. COOPER, Lt. MC USN  
 M. D. or other ...  
 Address USNH Bethesda, Md. Date signed 5-10-48

Registrar

RECEIVED

MAY 13 1948.

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of

age and birth date shown on:

FDM No. G 116 JUN -7 1948

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05133

Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County MONTGOMERYCity or town TAKOMA PARK  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 YR.

Hospital, institution, or street address where death occurred:

100 BALTIMORE AVENUE

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Col. County Washington, D.C.City or town WASHINGTON, D.C.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 6627 FIRST ST. N.W.  
(If rural, give LOCATION)2.(c) If veteran, name war ☒

## 3.(a) FULL NAME

MRS MARY LOUISE DE MOII

## 3.(b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced W6.(b) Name of husband or wife THEODORE G.7. Birth date of deceased (mo., day, yr.) ? ? 11/5/71 1854 6.(c) If alive, give age 118 years8. AGE: Years 92 Months 94 Days 94 If less than one day 94 hrs. 94 min.9. Birthplace WASHINGTON, D.C.  
(Town, county, and state)10. Usual occupation —11. Industry or business —12. Name FREDERICK STINZING13. Birthplace GERMANY14. Maiden name MARY ?15. Birthplace GERMANY16. Informant FREDERICK J. de MOII - SONAddress 6627 1st St. N.W. - D.C.17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof June 1, 1948  
(month) (day) (year)Cemetery or crematory Rock Creek Cem.Location WASHINGTON D.C.18. Funeral director Joseph SchubertAddress 1756 Penn. Ave. N.W.19. May 25 19 48 Registrar J. Schmidt

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 27, 1948 at 11:45 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 34 to May 27, 1948and that I last saw him alive on May 27, 1948Immediate cause of death Cardiac failure DURATION 2 daysDue to Old ageDue to Chronic Arthritis 15 yrs.Other conditions Chronic Arthritis

(Include pregnancy within 8 months of death)

Major findings of operations None Date of op. —Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

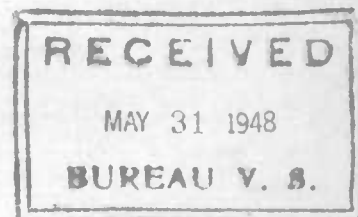
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Raymond H. Hager M.D. M.D. or otherAddress 6940 Pithers Dr. Rd. N.W. Date signed 5/28/48

~~1854~~  
76  
1948



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 05134 216

### 1. PLACE OF DEATH:

County Montgomery  
Bethesda (rural)  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 day  
Hospital, institution, or street address where death occurred:  
U. S. NAVAL HOSPITAL, Bethesda, Md.  
How long in hospital or institution? 1 day

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington, D. C. County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 5415 Livingston Road, S. E.  
(If rural, give LOCATION)  
2.(a) If veteran, name war..... ✓

### 3. (a) FULL NAME

DENYER, Richard "B"

### 3. (b) Social Security Number

4. Sex Male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) February 17, 1948 8. (c) If alive, give age..... years

8. AGE: Years 2 Months 27 Days 27 If less than one day..... hr. .... min.

9. Birthplace Washington, D. C.  
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name DENYER, Walter Thomas  
13. Birthplace Pa.

14. Maiden name TAYLOR, Margaret E.  
15. Birthplace Utah

16. Informant father: Mr. Walter T. Denyer  
Address 5415 Livingston Rd., S.E., Washington, D. C.

17. burial Date thereof 5-17-48  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematory Cedar Hill P.I.A.  
Location Prince George County, Md.

18. Funeral director W. W. Chambers  
Address 517 11th St., S.E., Washington, D. C.

19. 5-11- 19 48 Mary C. Patterson  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 14 May 19 48 at 8:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 13 May 19 48, to 14 May 19 48, and that I last saw him alive on 14 May 19 48.

Immediate cause of death atelectasis of lungs - all lobes

Due to Congenital heart disease with

Due to Left sided failure and bronchobronchitis

Other conditions Cachexia

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results CONFIRMED ABOVE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of.....  
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
Means of injury..... Injured at work?

A.M. Margileth  
23. SIGNATURE A.M. MARGILETH, Lt. JG. MC USN  
M. D. or other

Address USNH Bethesda, Md. Date signed 5-11-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 18 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 714

## 1. PLACE OF DEATH:

County MontgomeryCity or town Gloverly  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Montgomery County MontgomeryCity or town Gloverly  
(If outside city or town limits, write RURAL and give nearest town)Street No. Coleville Pike RFD #3 Rockville  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

HARRY RAY DOYLE

## 3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

MARRIED

6. (b) Name of husband or wife

M. ANITA DOYLE

7. Birth date of

deceased (mo., day, yr.)

APRIL 8, 1895

6. (c) If alive, give age years

8. AGE:

53113

If less than one day

hrs.

min.

9. Birthplace

NR SMITHSBURG, MD.

(Town, county, and state)

10. Usual occupation

MINISTER

11. Industry or business

SDA DENOMINATION

12. Name

Just Emory Doyle

13. Birthplace

Ind. Co., Md.

14. Maiden name

Annie Elizabeth Oden

15. Birthplace

Frederick Co. Md.

16. Informant

Mrs. M. Anita Doyle

Address

Gloverly - Md.

17. (Burial, cremation, or removal, which?)

Burial

Date thereof

May 23 - 1948

Cemetery or crematory

Smithsburg - Md.

Location

Smithsburg - Md.

18. Funeral director

Arthur Walters

Address

1354 - Carroll St. - Takoma Park

19. (Date rec'd by registrar)

May 21, 1948Jasper W. Schaffer

Registrar

23. SIGNATURE

Wallace N. Mook M.D.  
M. D. or other  
Takoma Park, Md. Date signed 5-21-48

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 21, 1948 at 9:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 21, 1946 to May 20, 1948and that I last saw him alive on May 20, 1948

Immediate cause of death

Arrival  
fibrillation with Con-  
gestive heart failure  
Rheumatic heart  
disease with Mitral  
Stenosis

DURATION

2 1/2 yrs.40 yrs.or so.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

RECEIVED  
MAY 29 1948  
BUREAU. V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05136

93d

Reg. Dist. No. 13

## 1. PLACE OF DEATH:

County... MontgomeryCity or town... Rockville, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State... Md. County... MontgomeryCity or town... Rockville  
(If outside city or town limits, write RURAL and give nearest town)Street No. ....  
(If rural, give LOCATION)

2.(a) If veteran, name war .....

## 3.(a) FULL NAME

Annie V. Duffin

## 3.(b) Social Security Number

none

4. Sex

Female

5. Color or race

Colored

6.(a) Single, married, widowed, or divorced

Widowed

## MEDICAL CERTIFICATION

20. DATE OF DEATH... MAY 29 1948, at 1:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

FEB 26 1946, to 3/24 1948  
and that I last saw h... OK alive on 3/23 1948

Immediate cause of death .....

Coronary Heart Failure

DURATION

2 W.

Due to...

Arteriosclerotic

Due to...

Heart Disease2 Y-6 W

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. .... Date of .....

Where did injury occur? .....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) .....

Means of injury .....

Injured at work?

23. SIGNATURE .....

W. Webb

M. D. or other

Address... Rockville, Md.Date signed 5/29/48

MOTHER FATHER

12. Name...

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, which?)

Date thereof...

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

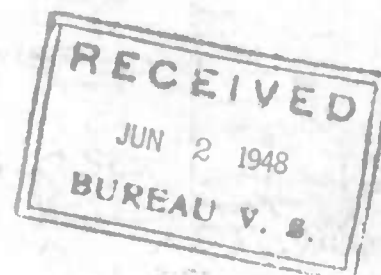
Address

19.

(Date rec'd by registrar)

1948

Registrar





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05137

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 9 months, 23 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 9 months, 23 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 6677 Whitehouse Road, S.E.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war WWI ✓

## 3.(a) FULL NAME

DUTROW, Lawrence Edgar

## 3.(b) Social Security Number

4. Sex male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Mrs. Dorothy Dutrow  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) January 16, 1897  
 8. AGE: Years 51 Months 3 Days 4 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace W. Va.  
 (Town, county, and state)  
 10. Usual occupation Guard  
 11. Industry or business Potomac Power Co., Wash., D.C.  
 12. Name DUTROW, Cornelius dec.  
 13. Birthplace Md.  
 14. Maiden name ? Margaret Jane dec.  
 15. Birthplace Md.

16. Informant wife: Mrs. Dorothy Dutrow  
 Address 6677 Whitehouse Rd., S.E., Wash., D.C.  
 17. burial Date thereof May 13, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory \_\_\_\_\_  
 Location Forrest Ville, Md.  
 18. Funeral director Ritchie Brothers, Inc.  
 Address Upper Marlboro, Md.  
 19. 5-10 48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 10 May 1948 at 9:20 A  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 17 July 1947 to 10 May 1948  
 and that I last saw him alive on 10 May 1948

Immediate cause of death  
Sarcoma, reticulum cell, diffuse

## DURATION

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

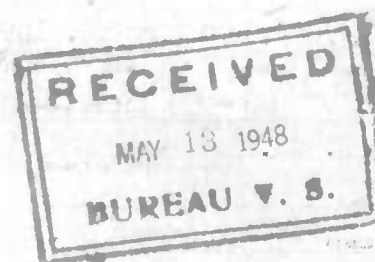
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, term, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE C. A. Mead, Jr. LT JG MC USN  
 M. D. or other \_\_\_\_\_Address USNH Bethesda, Md. Date signed 5-10-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

182

05138

Reg. Dist. No. 213

1. PLACE OF DEATH:  
 County Montgomery  
 City or town Rockville (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 1/2 mo  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County Montg.  
 City or town Rockville - Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2(a) If veteran, name war No

## 3. (a) FULL NAME

Charlotte Lucille Earp

## 3. (b) Social Security Number

home

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced single  
 6. (b) Name of husband or wife None  
 7. Birth date of deceased (mo., day, yr.) Jan 20 1948  
 8. AGE: Years 0 Months 3 Days 16 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Montg. Co. Md  
 (Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Emment Earp

13. Birthplace md

14. Maiden name Dorothy Richetta

15. Birthplace md

16. Informant Mrs. Emment Earp

Address Rockville md

17. Burial Date thereof May 8, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Potomac Chapel Cemetery

Location Potomac, Maryland

18. Funeral director W. Reuben Humphrey

Address Bethesda, Maryland

19. 5-8-48 19 \_\_\_\_\_  
 (Date rec'd by registrar) Registrar W. J. Thompson

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 1948 at 7:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Def. med. Exam case 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death \_\_\_\_\_

Asphyxia

Due to asphyxia

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accidental Date of 5-6-48

Where did injury occur? Rockville (City or town) Montg. (County) md (State)

Injured at home, farm, industry, public place (where?) home

Means of injury asphyxia Injured at work?

23. SIGNATURE Frank J. Brothart M.D.

Def. med. Exam M. D. or other

Address Washington md Date signed 5-6-48

## DURATION

Small  
child  
crib

**RECEIVED**

MAY 12 1948

**BUREAU V. S.**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

05139

216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 1/2 daysHospital, institution, or street address where death occurred:  
Suburban Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State New Jersey CountyCity or town Maywood  
(If outside city or town limits, write RURAL and give nearest town)Street No. 37 Magnolia Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war No

## 3. (a) FULL NAME

FREDERICK GARMAN FELLINGER

## 3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife Ida J. Fellingner

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 27, 18758. AGE: Years Months Days If less than one day  
71 2 10 hrs. min.9. Birthplace Hagerstown, Washington, Maryland  
(Town, county, and state)10. Usual occupation Printer

11. Industry or business

12. Name Philip Fellingner13. Birthplace New York14. Maiden name Elizabeth Garman15. Birthplace Hagerstown, Md.18. Informant Mr. F.G. KayhoeAddress 200 Sycamore St, Chevy Chase, Md.17. Burial Date thereof June 2, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory GlenwoodLocation Washington D.C.18. Funeral director Wm Reuben PumphreyAddress 7557 Wis. Ave. Bethesda, Md.19. 6/3 19 48 Wm E. Jones  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 31 May 19 48 at 3:20 A. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
4 May 19 48, to 31 May 19 48and that I last saw him alive on 30 May 19 48

Immediate cause of death

congestive failure, acute

DURATION

4 daysDue to Uremia, acute4 days

Due to

Other conditions Malignancy of abdominal organs (stomach and liver)?

(Include pregnancy within 3 months of death)

Major findings of operations Stage undetermined throughout stomach & liverDate of op. 28 May 48Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Herbert Martyn J. M.D.Address 1332 Mass. Ave. NW Date signed 31 May 48

RECEIVED

JUN 11 1948

BUREAU V. S.

05140

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 214

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda, Md. Co. & Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 33 yrs  
 Hospital, institution, or street address where death occurred Final Discharge

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Silver Spring  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1920 Glen Rose Rd  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Eleanor M. Ferguson

## 3. (b) Social Security Number

212-03-6865

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Warren T. Ferguson

7. Birth date of deceased (mo., day, yr.)

March 10, 1883

6. (c) If alive, give age years

8. AGE:

65

Months

1

Days

25

If less than one day

hrs.

min.

9. Birthplace

Oil City, Pa.

(Town, county, and state)

10. Usual occupation

Telephone Operator

11. Industry or business

C &amp; P Telephone Co.

MOTHER FATHER

12. Name

Alfred Shapland

13. Birthplace

SCOTLAND

14. Maiden name

Georgiana bouthan

15. Birthplace

VIRGINIA

16. Informant

ROBERT A. FERGUSON

Address

Silver Spring, Md

17.

BURIAL  
(Burial, cremation, or removal, Which?)

Date thereof

MAY 7, 1948  
(month) (day) (year)

Cemetery or crematory

GLENWOOD

Location

WASHINGTON, D.C.

18. Funeral director

Warner E. Pumphrey, Inc

Address

Silver Spring, Md

19.

May 6, 1948  
(Date rec'd by registrar)

1948

Josephine Schaeffer

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

May 5, 1948, at 12:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 4, 1948, to May 5, 1948, and that I last saw him alive on May 5, 1948

Immediate cause of death

acute congestive failure

DURATION

5 hr.

Due to

acute coronary occlusion

3 hrs

Due to

Other conditions

mild diabetes

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John S. Rogers, MD

M. D. or other

Address

5600 Rly Pl, Silver Spring, Md

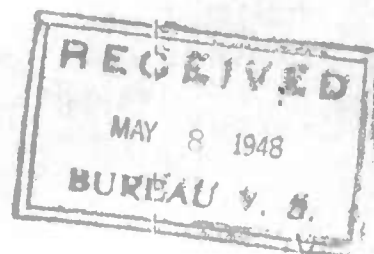
Date signed

May 5, 1948

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





# CERTIFICATE OF ~~STILLBIRTH~~ BIRTH & DEATH

Reg. Dist. No.

216

A certificate must be filed within 24 hours for every still birth of 20 weeks' gestation or more (see stub)

## 1. PLACE OF BIRTH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street address, hospital, or institution:  
US Naval Hospital, Bethesda, Md.  
 Length of mother's stay in County 1 day  
 (How many years, or months, or days. SPECIFY WHICH)

## 2. USUAL RESIDENCE OF MOTHER:

State Washington, D.C.  
 County \_\_\_\_\_  
 City or town \_\_\_\_\_  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1343 Euclid St., N. W.  
 (If RURAL give LOCATION)

3. Name of child FLEMMING, Baby Girl  
 5. Sex female 6. Twin or triplet -

4. Date of birth May 7 1948 Hour 12:25 P.M.  
 7. No. of weeks pregnancy 7½ months

## FATHER OF CHILD

8. Full name FLEMMING, David J.  
 9. Color W-US 10. Age at time of this birth ? yrs.  
 11. Usual occupation Navy

## MOTHER OF CHILD

12. Full maiden name PETROSKI, Helen  
 13. Color W-US 14. Age at time of this birth 29 yrs.  
 15. Usual occupation housewife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? \_\_\_\_\_  
 (b) How many other children were born alive but are now dead? \_\_\_\_\_ (c) How many other children were born dead? \_\_\_\_\_

17. Did child die before labor? \_\_\_\_\_ During labor? \_\_\_\_\_

18. Pregnancy, complications of \_\_\_\_\_

19. Labor: (a) Complications of \_\_\_\_\_

(b) Induced? \_\_\_\_\_

20. (a) Was there an operation for delivery? \_\_\_\_\_ (Yes or No)

(b) State all operations, if any \_\_\_\_\_

(c) Did child die before operation? \_\_\_\_\_

During operation? \_\_\_\_\_

23. (a) burial (b) Date thereof 5-11-48  
 (Burial, cremation or removal) (month) (day) (year)

(c) Cemetery or crematory Arlington National

24. (a) Funeral director Chambers

(b) Address 3072 M Street N.W. Riverdale 1e, Md.

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes asphyxia - generalized

(b) Maternal causes Placenta previa

22. I certify to the birth of this child who was born dead\* on the date and hour above stated.

Signature K. Patterson

(Specify if M. D., midwife, or other)

Address US Naval Hospital, Bethesda, Md.

25. (a) 5-9-48 (b) 13 Mary C. Patterson  
 (Date rec'd by registrar) (Registrar)

26. (To be filled out if no physician was present at delivery.)  
 The above certificate has been examined by me.

Health Officer, per \_\_\_\_\_

\* See Instruction C on stub.

RECEIVED

MAY 13 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

05141 217

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Brinklow Rural  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Brinklow  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. ....  
 (If rural, give LOCATION)

2.(a) If veteran, name war .....

## 3. (a) FULL NAME

William B. Frazier  
 4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Single

## 3. (b) Social Security Number

218-24-6937

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1945 at 3:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep. med exam case 1945 to 1945  
 and that I last saw him alive on 1945

Immediate cause of death

Hemorrhage due to  
fracture of skull  
(accidental)

DURATION

few  
min.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of

Where did injury occur? Brinklow Md (City or town) Montgomery (County) Md (State)

Injured at home, farm, industry, public place (where?) farmMeans of injury fell from horse Injured at work? yes

23. SIGNATURE Frank J. Broschart M.D.  
Dep. med. exam M. D. or other

Address Gaithersburg Md Date signed 6:5:48

## 11. Industry or business

12. Name Theodore Roosevelt Frazier13. Birthplace Gaithersburg, Md.14. Maiden name Mabel Anna Lee15. Birthplace Sandy Spring, Md.16. Informant Theodore Roosevelt FrazierAddress Brinklow, Md.17. Burial Date thereof May 8 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematorium Brook Grove MdLocation Lafayetteville Md18. Funeral director Rob W BarberAddress Jeffersonville Md19. 5/5 1948 Estimud B Lawler

(Date rec'd by registrar) Registrar

RECEIVED  
JUN 11 1948  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 218

## 1. PLACE OF DEATH:

County MontgomeryCity or town Gaithersburg  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 374 5900

Hospital, institution, or street address where death occurred:

Seabury Methodist Home

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County MontgomeryCity or town Gaithersburg  
(If outside city or town limits, write RURAL and give nearest town)Street No. Seabury Methodist Home  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Mary Virginia Galloway

## 3. (b) Social Security Number

## 4. Sex

female

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

widow

## 6. (b) Name of husband or wife

William J. Galloway

## 7. Birth date of deceased (mo., day, yr.)

Aug - 6 - 1868

## 6. (c) If alive, give age years

## 8. AGE:

87912

## If less than one day

✓ hrs.✓ min.

## 9. Birthplace

Baltimore, Md.  
(Town, county, and state)

## 10. Usual occupation

housewife

## 11. Industry or business

home care

## MOTHER FATHER

## 12. Name

Benjamin F. Hugg

## 13. Birthplace

Md.

## 14. Maiden name

Dorothy Bekley

## 15. Birthplace

North Carolina

## 16. Informant

Herman M. Kelson

## Address

Gaithersburg, Md.

## 17.

Burial  
(Burial, cremation, or removal. Which?)

## Date thereof

5/21/48  
(month) (day) (year)

## Cemetery or crematory

Greenmount Cemetery

## Location

Baltimore, Md.

## 18. Funeral director

Quest C. Jackson

## Address

Gaithersburg, Md.

## 19.

May 19 1948  
(Date rec'd by registrar)

## 19.

Abraham G. Corke  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May - 18 - 1948 at 2:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May - 11 - 1948 to May - 18 - 1948and that I last saw him alive on May - 17 - 1948

## Immediate cause of death

Acute Heart Failure

## Due to

Myocardial Degeneration

## Due to

Coronary Insufficiency

## Other conditions

Hypertension

(Include pregnancy within 3 months of death)

## Major findings of operations

## Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

William C. Miller, M.D.

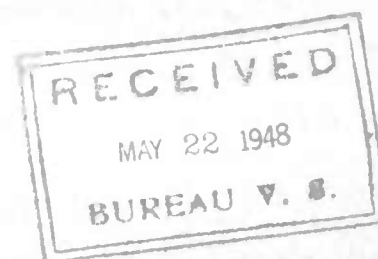
M. D. or other

## Address

Gaithersburg, Md.

## Date signed

5/18/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 months, 5 days  
 Hospital, institution, or street address where death occurred:  
U. S. NAVAL HOSPITAL, Bethesda, Md.  
 How long in hospital or institution? 2 months, 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State D.C. County .....  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1167 Rhode Island Ave., N.W.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war WWI ✓

## 3. (a) FULL NAME

GARNER, Leonard James

## 3. (b) Social Security Number

4. Sex Male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Mrs. May Garner

7. Birth date of deceased (mo., day, yr.) 11 October 1890  
 6.(c) If alive, give age ..... years

8. AGE: Years 57 Months 7 Days 16 If less than one day ..... hrs. .... min.

9. Birthplace England  
 (Town, county, and state)

10. Usual occupation Civil Service

11. Industry or business

12. Name GARNER, Francis J. dec.13. Birthplace England14. Maiden name GEE, Emelie dec.15. Birthplace England16. Informant wife: Mrs. May Garner

Address 1167 Rhode Island Ave. Washington, D. C.  
N.W.

17. burial Date thereof 6-1-48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Arlington NationalLocation Arlington, Virginia18. Funeral director W. W. Chambers Funeral Home

Address 11400 Chapin St. N.W. Washington, D. C.  
N.W.

19. 5-27 1948 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 27 May 19 48 21. 10:50A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
22 March 19 48 to 27 May 19 48

and that I last saw him alive on 27 May 19 48

Immediate cause of death Pulmonary edema DURATION

Due to Carcinoma - generalized

Due to Carcinoma - secondary

Other conditions Metastasis

(Include pregnancy within 8 months of death)

Major findings of operations Metastatic carcinoma

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ..... Injured at work?

Means of injury Penetration of tumor

23. SIGNATURE R. K. SMYDERMAN, Lt. JG MCR USNR

Address USNH Bethesda, Md. Date signed 5-27-48

**RECEIVED**

JUN 3 1948

BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 226

05144

50x

### 1. PLACE OF DEATH:

County... Montgomery

City or town... Cherry Chase, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 38 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Montgomery

City or town... Cherry Chase  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Frances M. Gauntlett

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife... Frederic John Gauntlett

7. Birth date of deceased (mo., day, yr.) 1878

6.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 70. Months \_\_\_\_\_ Days \_\_\_\_\_ It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace... Chicago, N. Y.  
(Town, county, and State)

10. Usual occupation... Housewife

11. Industry or business Home

12. Name... Elma Miles

13. Birthplace N. Y.

14. Maiden name... Elizabeth Bacon

15. Birthplace N. Y.

16. Informant... Frederick John Gauntlett

Address... 16 Primrose St. Ch. Ch. Md.

17. Burial Date thereof... MAY 31 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Rock Creek Cemetery

Location... Washington D.C.

18. Funeral director... Martin R. Hyson Co.

Address... 1300 N. St. N.W.

19. 5/29 19 48 Wm E. Jones  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH... May 29 19 48 at 9:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 19 47 to May 29 19 48  
and that I last saw him alive on May 29 19 48

Immediate cause of death... paroxysm of the heart, fatal with metastasis to lungs & mediastinum

### DURATION

Due to... Chronic

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op. \_\_\_\_\_

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Charles C. Law M. D. or other

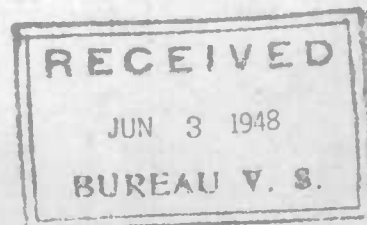
Address... 915 - 19th St. N.W. Date signed 5-29-48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1878  
26  
1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

122a

05145

Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County MontgomeryCity or town Lakewood Park, Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 mo. 14 days

Hospital, institution, or street address where death occurred:

Washington Sanitarium & HospitalHow long in hospital or institution? 1 month 14 days

## 3. (a) FULL NAME

Gross, Louise C

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

December 21, 1868

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

7953

hrs.

min.

9. Birthplace Wassier, New York.

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

Phillip Crippen

13. Birthplace

New York

14. Maiden name

Caroline Bigelow

15. Birthplace

New York16. Informant Sanitarium Records

Address

Washington Sanitarium & Hospital

17.

Burial

Date thereof

May 26, 1948

(Burial, cremation, or removal, Which?)

Cemetery or crematory

Maple Grove Cemetery

Location

Wassier, New York

18. Funeral director

J. Arthur Dallas

Address

254 Carroll St. N.W., Lakewood Park, Md.

19.

May 24

19

48

(Date read by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

New York

County

City or town

Wassier, Albany

(If outside city or town limits, write RURAL and give nearest town)

Street No.

23 Edgewood Ave.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH 5-24-48 19 48 at 3:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3-5 19 48 to 5-24 19 48and that I last saw him alive on 5-23 19 48

Immediate cause of death

Pulmonary Congestion & heart failure

DURATION

Due to

Following operation for strangulated hernia

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Left strangulated hernia

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Date signed

5-24-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05145

218

Reg. Dist. No. ....

1. PLACE OF DEATH: Montgomery  
County.....  
City or town..... Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... 6 days  
Hospital, institution, or street address where death occurred:  
U. S. NAVAL HOSPITAL, Bethesda, Md.  
How long in hospital or institution?..... 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... Washington, D. C. County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 607 Virginia Avenue, S.E.  
(If rural, give LOCATION)  
2.(a) If veteran, name war..... WWII ✓

3.(a) FULL NAME HALL, William Henson

3.(b) Social Security Number

4. Sex male 5. Color or race Col. US 6.(a) Single, married, widowed, or divorced married  
6.(b) Name of husband or wife..... Rachell Hall  
6.(c) If alive, give age..... years  
7. Birth date of deceased (mo., day, yr.) January 18, 1919  
8. AGE: Years 29 Months 3 Days 14 If less than one day  
..... hrs. .... min.

9. Birthplace..... Maryland  
(Town, county, and state)  
10. Usual occupation..... Worked at Carol Ann Dry  
11. Industry or business..... Cleaners.  
12. Name..... HALL, George dec.  
13. Birthplace..... Md.  
14. Maiden name..... WARD, Minnie dec  
15. Birthplace..... Md.

16. Informant..... wife: Mrs. Rachell Hall  
Address..... 607 Virginia Avenue, S. E., Wash., D.C.  
17. burial Date thereof..... 5-5-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory..... Arlington National  
Location..... Arlington, Va.

18. Funeral director..... W. Ernest Jarvis G. L. H.  
Address..... 1432 U St., N. W. Washington, D. C.  
5-3 48 Mary C. Patterson  
19. (Date rec'd by registrar)..... 19.....  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 2 19..... 48 at 7:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
26 April 19..... 48, to 2 May 19..... 48  
and that I last saw him alive on 2 May 19..... 48

Immediate cause of death..... Acute Hepatitis  
of hepatitis

DURATION

10 days

Due to..... carbon tetrachloride 10 days

Due to..... poisoning tetrachloride  
history of having worked with carbon tetrachloride

Other conditions..... acute Nephritis (toxic) 10 days  
Nephritis

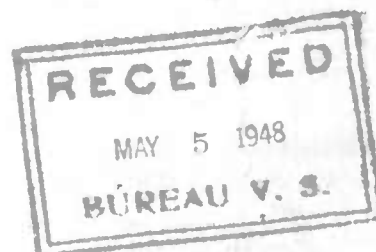
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results..... carbon tetrachloride  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Accident Date of.....  
Where did injury occur?..... (City or town)..... (County)..... (State).....  
Injured at home, farm, industry, public place (where?)..... Industry  
Means of injury..... Injured at work?..... yes 6/28/48

23. SIGNATURE..... J. T. Jones, Jr. LT JG MC USN  
M. D. or other  
USNH Bethesda, Md.  
Date signed..... 5-3-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Potomac  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 MonthsHospital, institution, or street address where death occurred:  
Pine View Rest HomeHow long in hospital or institution? 6 Months

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington, D.C. County Washington, D.C.City or town Washington, D.C.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 3700 Massachusetts Avenue, N.W.  
(If rural, give LOCATION)2.(a) If veteran, name war No ✓

## 3. (a) FULL NAME

Josephine R. Hallinan

## 3. (b) Social Security Number

None

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Divorced6. (b) Name of husband or wife None

## 6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) July 13, 1868

## 8. AGE:

Years

Months

Days

If less than one day

7979102

hrs.

min.

9. Birthplace Chicago, Illinois  
(Town, county, and state)10. Usual occupation Teacher

11. Industry or business

12. Name James Redfield13. Birthplace Unknown14. Maiden name Cora Kennicott15. Birthplace Unknown16. Informant Mr. Donald McGuineas, Sr.Address 3700 Mass. Ave., N.W., Wash., D.C.17. Cremation Date thereof May 17, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Cedar Hill CrematoryLocation Prince George County18. Funeral director W. Reuben HumphreyAddress Bethesda, Maryland19. 5/16 19 48 Wm E Jones  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 15, 1948 19 48 at 3:40 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 Aug 19 46 to 15 May 19 48and that I last saw h. ex alive on 14 May 19 48Immediate cause of death Cardiovascular diseasewith left sided heart failure DURATION 5 yearsDue to arteriosclerosis 10 years

Due to \_\_\_\_\_

Other condition Cerebral thrombosis, left hemiplegia 2 yrsCarcinoma left breast 4 mos.  
(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE H. A. Greenan m.d. M. D. or other \_\_\_\_\_Address 1150 Connecticut Ave. Date signed 15 May '48

RECEIVED

MAY 2 1911

BUREAU V. H.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 212

## 1. PLACE OF DEATH:

County MontgomeryCity or town Rural - Clarksburg Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 months

Hospital, institution, or street address where death occurred:

Tremont Farm, R. 2, Clarksburg Maryland

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montg.City or town Clarksburg B. & O.  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)2(a) If veteran, name war World War I

## 3. (a) FULL NAME

LULU EDYTHE HAMLIN

## 3. (b) Social Security Number

## 4. Sex

F

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

WIDOWED6. (b) Name of husband or wife ADDISON E. HAMLIN

7. Birth date of deceased (mo., day, yr.)

FEB. 3, 1884

6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

Months

Days

If less than one day

64316

hrs.

min.

9. Birthplace ELLIOTS BORO

(Town, county, and state)

PENNA.

10. Usual occupation

NURSE

11. Industry or business

GOV'T.

## FATHER

12. Name WILLIAM POWER DELANCEY

13. Birthplace

PENNA.

## MOTHER

14. Maiden name

SUSAN WOLFE

15. Birthplace

PENNA.16. Informant HARRY E. HESSE

Address

TREMONT FARM, R. 2, CLARKSBURG, MD.17. BURIAL  
(Burial, cremation, or removal, Which?)

Date thereof

5-21-48  
(month) (day) (year)

Cemetery or crematory

Arlington National

Location

Arlington, Virginia

18. Funeral director

Tom. B. Hilton

Address

Barnesville, Md.19. May 20, 1948  
(Date rec'd by registrar)Mrs. C.C. Hilton  
By Mrs. C.C. Hilton Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 19, 1948 at 11:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. med exam case 19\_\_\_\_ to 19\_\_\_\_  
and that I last saw him alive on 19\_\_\_\_

Immediate cause of death

Coronary occlusion

## DURATION

sudden  
suddenly

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank J. Bruchart M.D.  
Sept. med exam M. D. or otherAddress Clarksburg Md Date signed 5-21-48

RECEIVED

MAY 28 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH

County Montgomery  
City or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred.

Suburban Hospital  
How long in hospital or institution? 16 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
City or town \_\_\_\_\_  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

MARY H. HARRIS

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Albert W. Harris

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.)

April 15, 1899

8. AGE:

Years

Months

Days

If less than one day

49

hrs.

min.

9. Birthplace

Albermarle North Carolina  
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Lache A. Moody

12. Name

Idelicia Austin

13. Birthplace

Albermarle, N. C.

14. Maiden name

Idelicia Austin

15. Birthplace

Albermarle, N. C.

16. Informant

Albert W. Harris

Address

Glen Echo, Md. 5/13/48

17. (Burial, cremation, or removal, Which?)

Burial

Date thereof

(month)

(day)

(year)

Cemetery or crematory

Nash Nat. Cem.

Location

Springfield, Md.

18. Funeral director

W. W. Chambers Co.

Address

3072 - M. St. N.W. Wash. D.C.19. 57 11 1948

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 11 1948 19\_\_\_\_ at 6 A21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10, 1948 to May 10, 1948and that I last saw him/her alive on May 10, 1948

Immediate cause of death

Coronary thrombosis

DURATION

suddenlyDue to A was under treatment formorphine poisoning (24 gr)Due to taken with suicidal intent about24 hr before death. Was cautiousOther conditions drinking, and feeling fine when shepassed away. Coronary & Bronchial

(Include pregnancy within 3 months of death)

Major findings of operations advised me to sign certificatefrom natural causes.

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

Signature C P Ryland23. SIGNATURE C. P. RYLAND, M. D. M. D. or other \_\_\_\_\_Address 4901 MASSACHUSETTS AVE., N. W. Date signed MAY 11 1948

WASHINGTON 16, D. C.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05150

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Jakoma Park  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 6 months  
 Hospital, institution, or street address where death occurred:  
603 Flower Avenue Jakoma Park Md  
 How long in hospital or institution? 6 months

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Montgomery  
 City or town Jakoma Park  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 603 Flower Avenue  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

MISS SARAH WYMAN HAY

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single  
 6.(b) Name of husband or wife  
 7. Birth date of deceased (mo., day, yr.) Sept. 15, 1850  
 8. AGE: Years 97 Months 7 Days 26 If less than one day  
 hrs. min.

9. Birthplace Alleghene  
 (Town, county, and state)  
 10. Usual occupation Retired School Teacher  
 11. Industry or business Education  
 12. Name Frederic J. Jay Hay  
 13. Birthplace South Carolina  
 14. Maiden name Adeline Wyman  
 15. Birthplace Mass.

16. Informant Mrs. Roy Jackson  
 Address 375 Park Avenue, New York City, New York  
 17. CREMATION Date thereof MAY 12, 1948  
 (Burial, cremation, or removal, Which) (month) (day) (year)

Cemetery or crematory CEDAR HILL CREMATORY  
 Location PENNA AVE EXT. SE  
 18. Funeral director Frederic J. Stollers  
 Address 254 Canal St. N.W. Atlanta Park D.C.  
 19. May - 12 19 48  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 19 48 at 11:05 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Def med. Exam case to 19  
 and that I last saw him alive on 19

Immediate cause of death Coronary occlusion  
 DURATION drift suddenly

Due to  
 Due to  
 Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Frank J. Brochart M.D.  
Def med. Exam M. D. or other  
 Address Frederic J. Stollers Date signed 5-12-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 15 1948

BUREAU V. S.

PLEASE, WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05151

Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County MontgomeryCity or town Patoma Park  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

36 Columbia Avenue

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.County MontgomeryCity or town Patoma Park  
(If outside city or town limits, write RURAL and give nearest town)Street No. 36 Columbia Avenue  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

JOHN T. HENDERSON

## 3. (b) Social Security Number

578 05 7188

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Mayne C. Henderson

6. (c) If alive, give age years

## 7. Birth date of deceased (mo., day, yr.)

December 14, 1879

## 8. AGE:

Years

Months

Days

If less than one day

68429

hrs.

min.

## 9. Birthplace

Baltimore, Md.  
(Town, county and state)

## 10. Usual occupation

Supervisor Shipping Dept.

## 11. Industry or business

E. J. Schaefer Lumbering Supply Co.

## FATHER

## 12. Name

John Henderson

## 13. Birthplace

Md.

## MOTHER

## 14. Maiden name

Frances Sinclair

## 15. Birthplace

Md.

## 16. Informant

Gordon HendersonAddress 36 Columbia Ave. 2nd. Park. Md.

## 17.

(Burial, cremation, or removal. Which?)

Date thereof

May 15, 1948  
(month) (day) (year)

## Cemetery or crematory

Rock Creek Cemetery

## Location

Rock Creek Church Rd. Wash. D.C.

## 18. Funeral director

Arthur J. Galt

## Address

354 Capitol St., Capitol Park, D.C.

## 19.

(Date rec'd by Registrar)

May 13 1948

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

5-13

19

48

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9-2

19

47

to

5-13

19

48

and that I last saw him

alive on

Apr 22

19

48

Immediate cause of death

Acute Circulatory collapse

DURATION

Due to

Internal Hemorrhage

Due to

Carcinoma of Stomach with metastasis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

Wesley N. Harding M.D.

M. D. or other

Address

113 Carroll St. NW

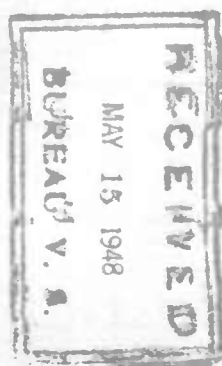
Date signed

5-13-48



Coroner of Montgomery County,  
Md. notified & appeared.

Attending N.S.  
5-13-48





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. Y14

## 1. PLACE OF DEATH:

County MONTGOMERYCity or town Chevy Chase  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County MONTGOMERYCity or town Chevy Chase  
(If outside city or town limits, write RURAL and give nearest town)Street No. 433 Shepherd St

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Caroline Milton

## 3. (b) Social Security Number

None

4. Sex

FEMALE

5. Color or race

White

6. (a) Single, married, widowed, or divorced

MARRIED

6. (b) Name of husband or wife

HENRY M. Hertel

7. Birth date of deceased (mo., day, yr.)

Sept. 4 18936. (c) If alive, give age 51 years

8. AGE:

Years

Months

Days

If less than one day

54823

hrs.

min.

9. Birthplace

Washington, D.C.  
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER  
MOTHER

12. Name

John S. White

13. Birthplace

Washington, D.C.

14. Maiden name

Ada Louise Reed

15. Birthplace

Washington, D.C.

16. Informant

HENRY M. HERTEL

Address

433 Shepherd

17.

BURIAL  
(Burial, cremation, or removal. Which?)

Date thereof

MAY 29 1948  
(month) (day) (year)

Cemetery or crematory

NATIONAL MEM. PARK

Location

FAIRFAX COUNTY, VIRGINIA

18. Funeral director

The S.H. Hines Co

Address

2901 14th St N.W.

19.

May 27  
(Date rec'd by registrar)to Josephine Schaeffer  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

May 26, 1948 at 11:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 10, 1948 to May 26, 1948  
and that I last saw him alive on May 26, 1948

Immediate cause of death

Coronary occlusion

DURATION

1 hr. 12

Due to

Arteriosclerosis

Due to

Other conditions

Dist. Cardio-vascular - renal disease  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Philip A. Varner, M.D.  
M.D. or other

Address

7202 Conn. Ave.

Date signed

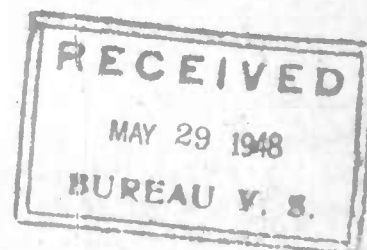
5/27/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

05153

B3a

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 months, 14 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 2 months, 14 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State D.C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1114 Que St., N.W.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war WWI ✓

## 3. (a) FULL NAME

HICKMAN, Rufus Burnie

## 3. (b) Social Security Number

4. Sex MALE 5. Color or race Col US 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Georgia Hickman

7. Birth date of deceased (mo., day, yr.) February 8, 1894  
 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 54 Months 2 Days 26 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace N.C.  
 (Town, county, and state)

10. Usual occupation Porter11. Industry or business Casualty Co., Wash., D.C.12. Name HICKMAN, George dec13. Birthplace N.C.14. Maiden name BLACKBURN, Fannie dec15. Birthplace N.C.16. Informant wife: Mrs. Georgia HickmanAddress 1114 Que St., N.W., Wash., D.C.

17. burial Date thereof 5-7-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington NationalLocation Arlington, Va.18. Funeral director Allen & Morrow S.P.M.Address 1326 V St., N.W., Wash., D.C.19. 5-4- 48 Mary C. Patterson

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 4 May 19 48 at 5:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 20 19 48 to 4 May 19 48  
 and that I last saw him alive on 4 May 19 48

Immediate cause of death Abscess Perinephritic, right DURATION 2½ months

Due to Pyonephrosis, right

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE H. J. COKELY, Capt. MC USN  
 M. D. or other \_\_\_\_\_

Address USNH Bethesda, Md. Date signed 5-4-48

RECEIVED

MAY 5 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

05154

## 1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 1/2 yrs

Hospital, institution, or street address where death occurred:

260 MAPLE AVE.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County MONTGOMERYCity or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)Street No. 260 MAPLE AVE  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

MRS. MARION C. HOWE

## 3.(b) Social Security Number

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

WIDOWED

6.(b) Name of husband or wife

DAVID M. HOWE

7. Birth date of

deceased (mo., day, yr.)

Jan 29, 1869

6.(c) If alive, give age..... years

8. AGE:

79

Years

Months

Days

If less than one day

..... hrs.

..... min.

9. Birthplace

Wash. DC.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof

5/27/48  
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. May 27, 1948

(Date rec'd by registrar)

19. 4819. 4819. 4819. 4819. 4819. 4819. 4819. 4819. 4819. 4819. 4819. 4819. 4819. 4819. 48

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 27<sup>th</sup> 1948 at 7:49 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 21<sup>st</sup> 1948 to May 26<sup>th</sup> 1948and that I last saw her alive on May 26<sup>th</sup> 1948Immediate cause of death IntestinalInfluenzaDiabetes Mellitus

DURATION

7 days40 yrs.

Due to

Other conditions ArteriosclerosisGeneralized

(Include pregnancy within 8 months of death)

10 yrs.

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Takoma Park, Md. Date signed 5-27-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 31 1948

BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05155

Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 1/2 hrs

Hospital, institution, or street address where death occurred:

Washington PostoriumHow long in hospital or institution? 20 1/2 hrs

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State \_\_\_\_\_ County \_\_\_\_\_

City or town Washington, D. C.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1832 - Irving St. N.W.  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_ ✓

## 3. (a) FULL NAME

Baby Ionescu COSTEL ANTONI, JR.

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White —

6. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) MAY April 6, 19488. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day 20 hrs. 30 min.9. Birthplace Takoma Park, Md.  
(Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name COSTEL A. IONESCU13. Birthplace Romania14. Maiden name THERESA ANNA CAMPANELLA15. Birthplace Wash, D.C.16. Informant Mrs. Theresa A. IonescuAddress 1832 - Irving St. N.W. Wash D.C.17. Burial Date thereof 5/8/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Fort LincolnLocation Bladensburg Rd. Md18. Funeral director W. Warren TaltavullAddress 3619-14th St. N.W. Wash D.C.19. May 7, 1948  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May April 7, 1948 at 6:10 a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-6 1948 to 5-7 1948  
and that I last saw him alive on 5-6- 1948

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Congenital Heart

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Partial Collapse R.lung and Enlarged  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W. Warren Taltavull M.D. M. D. or other \_\_\_\_\_Address 9601 Georgia Ave. Date signed 5/7/48

**RECEIVED**

MAY 11 1948

**BUREAU V. S.**

**RECEIVED**

MAY 12 1948

**BUREAU V. S.**



Evidence for change of  
birthdate shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05156

FILE No. G 116 JUN 25 1948 CERTIFICATE OF DEATH

Reg. Diat. No. 217

1. PLACE OF DEATH

County Montgomery  
City or town Laitshurst Md R.T.D. 2  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 10 years  
Hospital, institution, or street address where death occurred:  
Montgomery County Hospital Chrym  
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Montgomery  
City or town Laitshurst Md R.T.D. 2  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION) ✓  
2.(a) If veteran, name war \_\_\_\_\_

3. (a) FULL NAME

Mary Ellen Jackson

3. (b) Social Security Number

4. Sex Female 5. Color or race Col 6.(a) Single, married, widowed, or divorced Widowed  
6.(b) Name of husband or wife Robert Jackson  
7. Birth date of deceased (mo., day, yr.) Mar 12 1886 6.(c) If alive, give age \_\_\_\_\_ years  
8. AGE: Years 62 Months 2 Days 11 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
(Town, county, and state)  
10. Usual occupation none for years  
11. Industry or business none for years  
12. Name Hilda Dalmarah  
13. Birthplace Maryland  
14. Maiden name Shah Bowie  
15. Birthplace Maryland

16. Informant Sarah Jackson  
Address Laitshurst Md  
17. Burial, cremation, or removal. Which? Burial Date thereof May 25 - 1948  
(month) (day) (year)  
Cemetery or crematory Brooke Grove Md  
Location Laitshurst Md  
18. Funeral director Roy W Barker  
Address Laitshurst Md

19. May 25 19 48 Gertrude B Lawler  
(Date Rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 19 48 at 1:52 a.m.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 19 48 to May 22 19 48  
and that I last saw him alive on May 22 19 48  
Immediate cause of death Hemiparesis,  
right, acute,  
Due to Intra-cranial hemorrhage  
Due to Hypertensive - Cardio - Vascular Disease  
Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)  
Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Jack Summers M.D.  
Address Laitshurst Md Date signed May 24, 1948

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1948

1862

86

RECEIVED

JUN 17 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County MONTGOMERYCity or town TAKOMA PARK  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

114 CEDAR AVE.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD.County MONTGCity or town TAKOMA PARK  
(If outside city or town limits, write RURAL and give nearest town)Street No. 114 CEDAR AVE.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

MINERVA PURMAN JENKINS.

## 3. (b) Social Security Number

4. Sex

F.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

WIDOWED

6. (b) Name of husband or wife

BEN B. JENKINS.

7. Birth date of deceased (mo., day, yr.)

May 25, 1866

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

81118

hrs.

min.

9. Birthplace

Wisconsin

(Town, county, and state)

10. Usual occupation

AT HOME

11. Industry or business

FATHER

12. Name

Gray Purman

13. Birthplace

Unknown

MOTHER

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Mrs. Sadie C. Mc Intyre

Address

114 Cedar Ave. Tak. Park Md

17.

(Burial, cremation, or removal, Which?)

Date thereof

MAY 5 1948

(month) (day) (year)

Cemetery or crematory

York Lincoln Cemetery

Location

Blodensburg Rd + White Lane P. O. Co. Md

18. Funeral director

J. ARTHUR WALTERS

Address

254 CARROLL ST. N. W. TAKOMA PARK, D.C.

19.

(Date rec'd by registrar)

May 3 1948

Registrar

J. M. M. M. M.

## MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 3, 1948 at 12:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr. 21, 1947 to May 3, 1948and that I last saw him alive on May 2, 1948

Immediate cause of death

Coronary Thrombosis

DURATION

4 hrs.

Due to

Arterio-sclerosisInfarct

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. Blitt, M.D.

M. D. or other

Address

694 W. 4th St. N.W.

Date signed

5/3/48

RECEIVED

MAY 6 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05158

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? One day  
 Hospital, institution, or exact address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? one day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 5420 Conn. Ave., N.W.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

JOHNSON, Emeline Marie

## 3. (b) Social Security Number

4. Sex female 5. Color or race W-US 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Comdr. Paul Johnson, USN  
 7. Birth date of deceased (mo., day, yr.) October 1, 1905 8.(c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 42 Months 7 Days 12 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Vt.  
 (Town, county, and state)  
 10. Usual occupation housewife  
 11. Industry or business \_\_\_\_\_  
 12. Name CASSICK, William dec. \_\_\_\_\_  
 13. Birthplace Vt.  
 14. Maiden name REICH, Carolyn dec. \_\_\_\_\_  
 15. Birthplace S.C.

16. Informant husband: Comdr. Paul S. Johnson USN  
 Address 5420 Conn. Ave., N.W., Wash., D.C.  
 17. burial Date thereof 5-17-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Arlington National  
 Location Arlington, Va.  
 18. Funeral director S. H. HINES P. B. J.  
 Address 2901 14th St., N. W.  
 19. 5-17-48 Mary S. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 13 May 19 48 at 9:35 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 May 19 48 to 13 May 19 48  
 and that I last saw him alive on 13 May 19 48  
 Immediate cause of death Carcinoma of ovary DURATION \_\_\_\_\_

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 8 months of death)  
 Major findings of operations Entire abdomen filled with carcinoma Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE Paul Peterson, Capt. (MC) USN M. D. or other \_\_\_\_\_  
 Address USNH Bethesda, Md. Date signed 5-17-48

RECEIVED

MAY 19 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

Rockville 2500

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05159

Reg. Dist. No. 214

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Frederick  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 34  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Montgomery  
 City or town Frederick  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex male 5. Color or race col 6.(a) Single, married, widowed, or divorced single  
 6.(b) Name of husband or wife \_\_\_\_\_  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) unknown 1848?  
 8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.  
100 or more years old  
 9. Birthplace Maryland  
 (Town, county, and state)  
 10. Usual occupation labour  
 11. Industry or business farming  
 12. Name \_\_\_\_\_  
 13. Birthplace unknown  
 14. Maiden name \_\_\_\_\_  
 15. Birthplace \_\_\_\_\_

16. Informant \_\_\_\_\_  
 Address \_\_\_\_\_  
 17. Burial Date thereof May 13, 1948  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Good Hope Church  
 Location Colesville, Md  
 18. Funeral director R. L. Snowden  
 Address 246 N. Washington St.  
Rockville, Md  
 19. May 13 1948 Josephus Schaeff  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1948 at 3:45 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept med exam case to 19  
 and that I last saw him alive on 19  
 Immediate cause of death Coronary occlusion DURATION brief  
suddenly  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)  
 Major findings of operations \_\_\_\_\_  
 Date of op. \_\_\_\_\_  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE Frank J. Brachard M.D. D. or other \_\_\_\_\_  
Dr. med exam  
Yantherburg Md Date signed 5-11-48

RECEIVED

MAY 15 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Chevy Chase  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Mother's Home 6307 Broad Br. Rd.,

How long in hospital or institution? None

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Chevy Chase  
 (If outside city or town limits, write RURAL and give nearest town)Street No. 6307 Broad Branch Road,

(If rural, give LOCATION)

2. (a) If veteran, name war None

## 3. (a) FULL NAME

Joseph Francis Jones

## 3. (b) Social Security Number

Yes - Unknown

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Unknown

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

March 25, 1901

8. AGE:

Years

Months

Days

If less than one day

4747114

hrs.

min.

9. Birthplace Brooklyn, New York  
 (Town, county, and state)10. Usual occupation Clerk11. Industry or business Woodward & Lothrop

MOTHER FATHER

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden name

Madeline Jones

15. Birthplace

Brooklyn, New York16. Informant Father James M. HoganAddress St. Johns Church, Frederick, Md.17. Burial  
 (Burial, cremation, or removal. Which?)Date thereof May 13, 1948  
 (month) (day) (year)Cemetery or crematory St. Johns CemeteryLocation Frederick, Maryland

16. Funeral director

Address Bethesda, Maryland19. 5/12/48  
 (Date rec'd by registrar)19. 48Mr E Jones

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 1948, at ? P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Def med Exam to case  
 and that I last saw h. alive on 19

Immediate cause of death

DURATION

Due to Cerebral edema  
chronic alcoholismFound dead in bed  
1 w.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank J. Broschart M.D.

M. D. or other

Address Frederick Md Date signed 5-10-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05161

Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County... Montgomery  
 City or town... Takoma Park  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
208 Philadelphia Ave  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Montgomery  
 City or town... Takoma Park  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 208 Philadelphia Ave  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

DEAN W. JUDD

## 3. (b) Social Security Number

## 4. Sex

M

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

## 7. Birth date of deceased (mo., day, yr.)

June 21, 1881

## 6. (c) If alive, give age..... years

## 8. AGE:

66

Years

Months

Days

If less than one day

hrs.

min.

## 9. Birthplace

Cedar, Ohio

(Town, county, and state)

## 10. Usual occupation

Veteran

## 11. Industry or business

FATHER

## 12. Name

OSCAR JUDD

## 13. Birthplace

OHIO

MOTHER

## 14. Maiden name

## 15. Birthplace

OHIO

## 16. Informant

Mrs Louise E Judd

## Address

201 Hedges Lane, Takoma Park, Md

## 17.

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

## Cemetery or crematory

Cedar Hill Cemetery

## Location

Takoma Park &amp; E. Extended, Suitland, Md

## 18. Funeral director

## Address

254 Carroll Ave, Takoma Park, D.C.

## 19.

May 30 1948

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19 48

## MEDICAL CERTIFICATION

20. DATE OF DEATH... May 27 1948 at ? M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sup med Exam case  
 and that I last saw h... alive on 19...  
 Immediate cause of death

Coronary occlusion  
 Due to...  
 Due to...

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Address... Date signed... 5/30/48

SL 1871

*WV Jones*

RECEIVED  
JUN 3 1948  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

93d

05162

Reg. Dist. No. 211

## 1. PLACE OF DEATH:

County MontgomeryCity or town Cedar Grove Rural  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 30 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Cedar Grove Rural R & D  
(If outside city or town limits, write RURAL and give nearest town)Street No. 8  
(If rural, give LOCATION)2.(a) If veteran, name war ✓

## 3. (a) FULL NAME

Sarah W King

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife of Bradley J King7. Birth date of deceased (mo., day, year) Aug 30 - 18678. AGE: Years 80 Months 11 Days 5 If less than one day  
..... hrs. .... min.9. Birthplace MD  
(Town, county, and state)10. Usual occupation Home11. Industry or business Home12. Name Saskrah Bowden13. Birthplace MD14. Maiden name Johna Miller15. Birthplace MD16. Informant Bradley J KingAddress Cedar Grove MD17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof May 8 - 1948  
(month) (day) (year)Cemetery or crematory SalonLocation Cedar Grove MD18. Funeral director Robt W BarberAddress Washingtonville MD19. May 7 - 1948 Della V. Burdette  
(Date rec'd by Registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 19 48 at 4:00 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1 P. 19 48 to May 5 19 48  
and that I last saw h. ER. alive on April 31 19 48Immediate cause of death Arteriosclerotic cardio-vascular disease

## DURATION

30 yearsDue to Decubitus ulcers 3 weeks

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James P. Kerr, Jr.Address Hemadens, Ind. Date signed 5/6/48

RECEIVED

MAY 10 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05163

Reg. Dist. No.

216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban Hospital  
 How long in hospital or institution? 6 1/2 hours days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 9100 Georgetown Road  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

Delos O. Kinsman

## 3.(b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Anna B. Kinsman

7. Birth date of deceased (mo., day, yr.)

August 30, 1868

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

7982

hrs. min.

9. Birthplace

Fayette, Wisconsin  
(Town, county, and state)

10. Usual occupation

Professor

11. Industry or business

FATHER  
 MOTHER

12. Name

Thomas R. Kinsman

13. Birthplace

Wisconsin

14. Maiden name

Emma Harris

15. Birthplace

Cornwall, England

16. Informant

Mrs. Georgia K. Ioverud

Address

4540 45th St., N.W., Wash. D.C.

17.

(Burial, cremation, or removal. Which?)

Date thereof

5/7/48  
(month) (day) (year)

Cemetery or crematory

Cedar Hill Cem

Location

18. Funeral director

Joseph Gault's Son's

Address

1756 Penna Ave, N.W., Wash, D.C.

19.

(Date rec'd by registrar)

May 2 1948Wm G Jones  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1948 at 1:55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1938 to 5-2-48 1948and that I last saw him alive on 5-2-48 1948

Immediate cause of death

Uremia

DURATION

Due to

Cardio-Vascular - Renal Disease

Due to

Other conditions

Hypertension  
Hypostatic Pneumonia  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Karl Anstahl M.D.

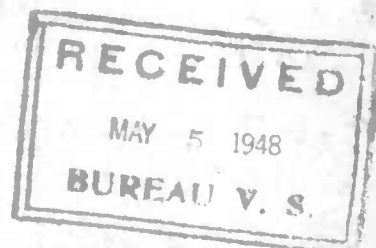
M. D. or other

Address

3130 Wis Ave.

Date signed

5/2/48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The contact age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05164

Reg. Diat. No. 716

## 1. PLACE OF DEATH

County MontgomeryCity or town Bethesda, Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 25 yrsHospital, institution, or street address where death occurred:  
4605 Highland Avenue,How long in hospital or institution? None

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Bethesda, Maryland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4605 Highland Avenue,  
(If rural, give LOCATION)2(a) If veteran, name war No

## 3. (a) FULL NAME

Henson Christopher Kraft

## 3. (b) Social Security Number

None

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Annie Kraft7. Birth date of deceased (mo., day, yr.) May 7, 1855  
6. (c) If alive, give age years8. AGE: Years Months Days If less than one day  
93 93 0 21 hrs. min.9. Birthplace Washington, D. C.  
(Town, county, and state)10. Usual occupation Retired Plaster11. Industry or business None12. Name Unknown-Kraft13. Birthplace Washington, D. C.14. Maiden name Unknown-Brown15. Birthplace Washington, D. C.16. Informant Frederick B. KraftAddress 4601 Highland Avenue Bethesda, Md.17. Burial Date thereof June 1, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Congressional CemeteryLocation Washington, D. C.18. Funeral director Wm Ruben HumphreyAddress Bethesda, Maryland19. 5/31 19 48 John E. Jones  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 19 48 at 12 30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 19 48 to May 28 19 48and that I last saw him alive on May 27 19 48Immediate cause of death Heart failure DURATIONDue to Arteriosclerotic heart diseaseDue to NoneOther conditions None

(Include pregnancy within 3 months of death)

Major findings of operations NoneDate of op. NoneAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of None

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles E. Hordson, M.D. M. D. or otherAddress 1515 Eye St. Date signed 5/28/48

RECEIVED

JUN 3 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 05165 714

## 1. PLACE OF DEATH:

County... MontgomeryCity or town... Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?... Since 3/12-39Hospital, institution or street address where death occurred... Cedarcroft SanitariumHow long in hospital or institution?... Since 3/12-39

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... D.C. County...City or town... Wash.  
(If outside city or town limits, write RURAL and give nearest town)Street No... 327-10 St. NW  
(If rural, give LOCATION)

2.(a) If veteran, name war...

## 3. (a) FULL NAME

Lula Lee

## 3. (b) Social Security Number

none4. Sex F. 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife...

6. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) August 17, 18878. AGE: Years 60 Months 9 Days 12 hrs. min.9. Birthplace... New Orleans, Louisiana  
(Town, county, and state)10. Usual occupation... School Teacher

11. Industry or business

12. Name... Walter John Lee13. Birthplace... Louisiana14. Maiden name... Lida Mae Lee15. Birthplace... Louisiana16. Informant... Miss Agnes Lee (sister)Address... 3212 Stephenson Pl., N.W., Wash., D.C.17. Burial Date thereof... June 1, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... Cedar HillLocation... Switland, Arden Rd18. Funeral director... Martin W. Nyson Co.Address... 1300 "N" St., N.W., Washington, D.C.19. May 5, 1948 (Date rec'd by registrar)19. Joseph Schaefer Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... May 29 - 1948, at 6:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar. 12 - 1939, to May 29 - 1948and that I last saw her alive on May 29 - 1948Immediate cause of death... Huntington's Chorea DURATION 2Due to... Exhaustion

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op. ...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

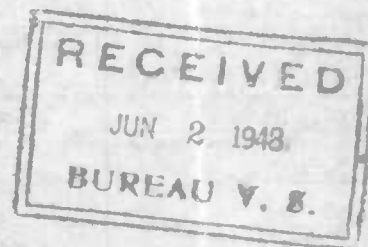
Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE... Richard B. Thibodeau M.D.Address... Cedarcroft Sanitarium Date signed... 5/29-48



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05166

Reg. Dist. No. 216

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 5 days  
Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
How long in hospital or institution? 5 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Penna. County \_\_\_\_\_  
City or town Rosemont  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

### 3.(a) FULL NAME

LEE, William Justice

### 3.(b) Social Security Number

### 4. Sex

male

### 5. Color or race

W-US

### 6.(a) Single, married, widowed, or divorced

divorced

### 6.(b) Name of husband or wife

### 7. Birth date of deceased (mo., day, yr.)

June 26, 1891

### 6.(c) If alive, give age \_\_\_\_\_ years

### 8. AGE:

Years

Months

Days

If less than one day

56

10

18

hrs.

min.

### 9. Birthplace

Pennsylvania

(Town, county, and state)

### 10. Usual occupation

Retired Navy

### 11. Industry or business

FATHER  
MOTHER

### 12. Name

LEE, Leighton

dec.

### 13. Birthplace

Pa.

### 14. Maiden name

JUSTICE, Mary

### 15. Birthplace

Pa.

### 16. Informant

brother: Mr. Phillip L. Lee

### Address

Rosemont, Pennsylvania

### 17.

burial cremation  
(Burial, cremation, or removal. Which?)

### Date thereof

May 17, 1948  
(month) (day) (year)

### Cemetery or crematory

Laurel Hill

### Location

Philadelphia, Penna.

### 19. Funeral director

J. Gawler Sons

### Address

1756 Penn. Ave., NW, Wash., D.C.

5-15

48

Mary Q. Patterson

19. (Date rec'd by registrar)

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 11 May 1948 at 7:15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 May 1948 to 11 May 1948

and that I last saw him alive on 11 May 1948

Immediate cause of death Pulmonary infarction DURATION

Massive Right

Due to Hypertensive Heart Disease

also 300 C. Pulmonary Rupture

apparently arrested (Mild for adv.)

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

### Major findings of operations

Date of op. \_\_\_\_\_

### Autopsy results

as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

### 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

### 23. SIGNATURE

C. H. C. Smith

C. H. C. SMITH, Cdr. MC M.D. or other

USNH Bethesda, Md.

Address \_\_\_\_\_ Date signed 5-15-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 18 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct, age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05167

Reg. Dist. No. 223-

## 1. PLACE OF DEATH:

County Maryland County.City or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 yrs.

Hospital, institution, or street address where death occurred:

Washington Sanatorium Hosp.How long in hospital or institution? 7 yrs.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town Stony Side  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Grace R. Leedy.

## 3. (b) Social Security Number

4. Sex F.5. Color or race White6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Russell J. Leedy7. Birth date of deceased (mo., day, yr.) Feb. 7, 19096. (c) If alive, give age 46 years8. AGE: Years 39 Months 3 Days 20 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Guthrie Iowa  
(Town, county, and state)10. Usual occupation House wife

## 11. Industry or business

12. Name John Blotch Bough13. Birthplace Germany14. Maiden name Eva Moore15. Birthplace Kentucky16. Informant Russell J. LeedyAddress Stony Side Md.17. Burial Date thereof 5/25/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Fort Lincoln CemeteryLocation Prince Georges County, Md.18. Funeral director S. H. Hines Co.Address 2901-14th St. N.W.19. May 22 1948 Registrar

(Date received by Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1948, at 5:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

\_\_\_\_\_ 19\_\_\_\_ to May 22 1948and that I last saw her alive on May 21 1948Immediate cause of death Acute hydrocephalusDURATION 3 daysDue to Cyst of choroid plexuswith ball-valve action

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results Cyst of choroid plexus

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE [Signature] M. D. or other \_\_\_\_\_Address Silver Spring Md. Date signed 5/22/48



1948-6-22

~~39-3-20~~

1969-7-1

~~39-3-20~~

1948-6-22

RECEIVED  
MAY 26 1948  
BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05168

186a

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 day  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Virginia County \_\_\_\_\_  
 City or town \_\_\_\_\_  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Purcellville  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

LIGHTNER, Ashton Lynn

## 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced single  
 6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) September 25, 1946  
 8. AGE: Years 1 Months 7 Days 18 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Virginia  
 (Town, county, and state)  
 10. Usual occupation \_\_\_\_\_  
 11. Industry or business \_\_\_\_\_  
 12. Name LIGHTNER, Thomas Ashton Lynn  
 13. Birthplace Haymarket, Va.  
 14. Maiden name TERRILL, Mary Benson  
 15. Birthplace Va.

16. Informant father: Lt. Thomas A. L. LIGHTNER, USN  
 Address Purcellville, Virginia  
 17. burial Date thereof May 15, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory St. Pauls Churchyard  
 Location Haymarket, Va.  
 18. Funeral director Jos. F. Birch's Sons  
 Address 3034 M St., N. W., Wash., D.C. HWS.  
5-14 48 Mary C. Patterson  
 (Date rec'd by registrar) 19. \_\_\_\_\_ Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 13 May 19 48, at 11:32 PM  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 13 May 19 48 to 13 May 19 48  
 and that I last saw him im alive on 13 May 19 48  
 Immediate cause of death DEPUTY MEDICAL EXAM. CASE DURATION \_\_\_\_\_

Cerebral hemorrhage  
fracture of skull 8 hrs.  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)  
 Major findings of operations \_\_\_\_\_  
 \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Accident Date of 5-13-48  
 Where did injury occur? Purcellville (City or town) VA (State)  
 Injured at home, farm, industry, public place (where?) Home  
 Means of injury fell from 2d floor window injured at work? no  
Frank J. Broschart M.D.  
 23. SIGNATURE Dep. Med. Exam. M. D. or other \_\_\_\_\_  
 Address Gaithersburg, Md. Date signed 5-14-48

**RECEIVED**

MAY 17 1948

**BUREAU V. S.**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05169

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County..... Montgomery  
 City or town..... Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 1 day  
 Hospital, institution, or street address where death occurred:  
U. S. NAVAL HOSPITAL, Bethesda, Md.  
 How long in hospital or institution?..... 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Md. County..... P.G.  
 City or town..... Capital Heights  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 6214 Kingston Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... Sp. Am.

## 3. (a) FULL NAME

LOCKWOOD, George (n)

## 3. (b) Social Security Number

|   |                                 |  |                    |
|---|---------------------------------|--|--------------------|
| 4. Sex<br><u>male</u>   | 5. Color or race<br><u>W-US</u> | 6. (a) Single, married, widowed, or divorced<br><u>married</u> |                    |
| 6. (b) Name of husband or wife..... <u>Hattie Lockwood</u>      |                                 |  |                    |
| 7. Birth date of deceased (mo., day, yr.) <u>May 23, 1874</u>   |                                 |  |                    |
| 8. AGE: Year Month Days If less than one day                    |                                 |  |                    |
| <u>73</u>   | <u>6</u>                        | <u>22</u>  | .....hrs. ....min. |
| 9. Birthplace..... <u>New York</u><br>(Town, county, and state) |                                 |  |                    |
| 10. Usual occupation.....                                       |                                 |  |                    |
| 11. Industry or business.....                                   |                                 |  |                    |
| 12. Name..... <u>unknown</u>                                    |                                 |  |                    |
| 13. Birthplace..... <u>unknown</u>                              |                                 |  |                    |
| 14. Maternal name..... <u>unknown</u>                           |                                 |  |                    |
| 15. Birthplace..... <u>unknown</u>                              |                                 |  |                    |

16. Informant wife: Mrs. Hattie Lockwood  
 Address 6214 Kingston Road, Capital Heights, Md.

17. burial Date thereof May 18, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Arlington National  
 Location Arlington, Va.

18. Funeral director Valley Funeral Home W. T. N.  
 Address 522 8th St., SE, Wash., D.C.

19. 5-15-48 x Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 15 May 19 48, at 3:20A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
14 May 19 48, to 15 May 19 48.  
 and that I last saw him alive on 15 May 19 48.

Immediate cause of death Congestion lung  
acute DURATION indf

Due to Thrombosis  
coronary artery multiple  
 Due to coronary heart disease  
arterio sclerosis  
 Other conditions mitral stenosis  
arterio sclerosis, obesity  
 (Include pregnancy within 3 months of death) marked

Major findings of operations.....

Autopsy results..... as above.  
 Date of op. ....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury W. T. N. Injured at work?

23. SIGNATURE..... F. E. WETZEL, Frederick E.  
Lieut. MC USN M. D. or other

Address..... USNH Bethesda, Md. Date signed..... 5-15-48

RECEIVED

MAY 19 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

113

05170

Reg. Dist. No. 218

## 1. PLACE OF DEATH:

County Moritz  
 City or town Germantown (Maryland)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 yrs  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md County Moritz  
 City or town Germantown Rural (Cedar Grove)  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Mellie G. Lowe  
 7. Birth date of deceased (mo., day, yr.) May 26 - 1897 6. (c) If alive, give age 43 years  
 8. AGE: Years 50 Months 11 Days 12 If less than one day hrs. \_\_\_\_\_ min. \_\_\_\_\_  
 9. Birthplace Porter Co. Ind. (Town, county, and state)  
 10. Usual occupation Labour  
 11. Industry or business \_\_\_\_\_  
 12. Name Samuel Lowe  
 13. Birthplace Md.  
 14. Maiden name Annie Bolton  
 15. Birthplace Md.

16. Informant Annie G. Lowe  
 Address Germantown Md  
 17. Burial Date thereof 5/11/48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Forest Oak Cemetery  
 Location Laithersburg Md.  
 18. Funeral director Ed. Carter  
 Address Laithersburg Md  
 19. May 10 1948 Abner G. Cook  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 1948 at 9:10 A.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. med. exam to 19  
 and that I last saw him alive on 19  
 Immediate cause of death \_\_\_\_\_  
Acute Cardiac Failure DURATION 6 hrs.  
 Due to Emphysema 4 yrs.  
Emphysema  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Frank J. Brontack M.D. M. D. or other \_\_\_\_\_  
Dep. med. exam  
 Address Laithersburg Md Date signed 5-8-48

**RECEIVED**

MAY 12 1948

BUREAU V. S.

**MARYLAND STATE DEPARTMENT OF HEALTH**

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

Reg. Diat. No

216

1. PLACE OF DEATH:  
County Montgomery  
City or town Bethesda, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? One half hour  
Hospital, institution, or street address where death occurred:  
Suburban Hospital  
How long in hospital or institution? One Half Hour

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County Montgomery  
City or town Bethesda, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 8712 Old Georgetown Road  
(If rural, give LOCATION)  
2.(a) If veteran, name war No

|                  |                      |                               |             |
|------------------|----------------------|-------------------------------|-------------|
| 3. (a) FULL NAME | Gerard Arthur Mahler | 3. (b) Social Security Number | Yes-Unknown |
|------------------|----------------------|-------------------------------|-------------|

|   |                  |   |                      |
|---|------------------|---|----------------------|
| 4. Sex  | 5. Color or race | 6.(a) Single, married, widowed, or divorced |                      |
| Male  | White            | Married                                     |                      |
| 6.(b) Name of husband or wife <u>Paula Elizabeth Mahler</u> |                  |   |                      |
| 7. Birth date of deceased (mo., day, yr.)                   |                  | 6.(c) If alive, give age <u>52</u> years    |                      |
| <u>April 25, 1895</u>                                       |                  |   |                      |
| 8. AGE:   | Years            | Months                                      | Days                 |
|   | 53               | 1   | 1                    |
|   |                  |   | If less than one day |
|   |                  |   | ..... hrs. .... min. |

9. Birthplace. Prague Czechoslovakia  
(Town, county, and state)

10. Usual occupation. Economist

11. Industry or business None

|               |                 |                        |
|---------------|-----------------|------------------------|
| MOTHER FATHER | 12. Name        | Arthur Mahler          |
|               | 13. Birthplace  | Prague, Czechoslovakia |
| MOTHER FATHER | 14. Maiden name | Erua Baner             |
|               | 15. Birthplace  | Vieuna Austria         |

16. Informant Wife-Mrs. G. A. Mahler  
Address Bethesda, Maryland

17. Burial Date thereof May 29, 1948  
(Burial, cremation, or removal, Which?) (month), (day), (year)

Cemetery or crematory..... Rock Creek Cemetery  
Location..... Washington, D. C.  
18. Funeral director..... W. Reuben Humphreys  
Address..... Bethesda, Maryland

19. 5/26 19 48 7th E Jones Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1948 at 1:30 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 26 1948, to May 26 1948 and that I last saw (P) alive on May 26 1948.

|                               |                |
|-------------------------------|----------------|
| Immediate cause of death..... | DURATION.....  |
| Coronary thrombosis.....      | 1 1/2 hrs..... |

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op. ....

Autopsy results.....

PHYSICIAN- Please underline the cause to which death should be charged statistically.

22. **VIOLENCE:** If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? .....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE [Signature] M. D. or other  
Address: 5410 16th St. S.E. Al. Date signed 5-26-48

RECEIVED

JUN 3 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

131a

05171

Reg. Dist. No. 223

## 1. PLACE OF DEATH

County MontgomeryCity or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 5 days

## 3. (a) FULL NAME

Carlton W. Martin

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington D.C. CountyCity or town Washington D.C.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1609 Conn. Ave. N.W.  
(If rural, give LOCATION)2. (a) If veteran, name war U.S. Navy - (1927-1931) ✓

## 3. (b) Social Security Number

## 4. Sex

male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

Separated

## 6. (b) Name of husband or wife

Helen

## 7. Birth date of deceased (mo., day, yr.)

June 4, 1908

## 6. (c) If alive, give age years

## 8. AGE:

Years

Months

Days

If less than one day

39116

hrs.

min.

## 9. Birthplace

Evans Mills N.Y.  
(Town, county, and state)

## 10. Usual occupation

Ballroom alley attendant

## 11. Industry or business

## MOTHER

## 12. Name

Wilson Rogers

## 13. Birthplace

Cleveland

## 14. Maiden name

Julia Baldwin

## 15. Birthplace

Cleveland

## 16. Informant

Russell B. Martin

## Address

1609 Conn. Ave. N.W.

## 17.

Burial

Date thereof

May 13, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

## Cemetery or crematory

Arlington National

## Location

Arlington Co., Virginia

## 18. Funeral director

Warner E. Humphrey, Inc.

## Address

8434 Georgia Ave., Silver Spring

## 19.

May 12, 1948  
(Date rec'd by registrar)

19 48

J. W. M. R. D. D.

J. W. M. R. D. D.

J. W. M. R. D. D.

J. W. M. R. D. D.

J. W. M. R. D. D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 10, 1948, at 3:37 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

May 5, 1948, to May 10, 1948and that I last saw him alive on May 10, 1948

## Immediate cause of death

Chronic state

## DURATION

Due to

Chronic Nephritis? years

Due to

Hypertension? years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Robert A. Farewell, M.D.  
Address Takoma Park, Md. Date signed 5/10/48

RECEIVED

MAY 15 1948

BUREAU 9. 9.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 05173

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Silver Spring  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

On lawn at 419 Mansfield Dr.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town Washington, D.C.  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 1424 R. St. N. W. Apt 2  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Thomas J. McGrail

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

malewhitemarried6. (b) Name of husband or wife Katherine S.

7. Birth date of deceased (mo., day, yr.) July 12, 1880  
 6. (c) If alive, give age..... years

8. AGE: Years Months Days If less than one day  
67 9 29 .....hrs. ....min.

9. Birthplace Penn.  
 (Town, county, and state)

10. Usual occupation Brocklayer

11. Industry or business

FATHER 12. Name unknown  
 13. Birthplace unknown

MOTHER 14. Maiden name unknown  
 15. Birthplace unknown

16. Informant Mrs Katherine McGrail  
 Address 1423 R. St, Apt 2 Wash. D.C.

17. Removal Date thereof May 11, 1948  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Washington, D.C.

Location

18. Funeral director P. J. Saffell

Address 475 H. St. N.W. Washington, D.C.

19. May 11 19 48 Josephine Schaeffer  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 19 48 at 7:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep med exam case 19..... to 19.....  
 and that I last saw h..... alive on 19.....

Immediate cause of death

DURATION

Coronary occlusion  
 Due to.....  
 Due to.....

Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings of operations

Date of op.....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

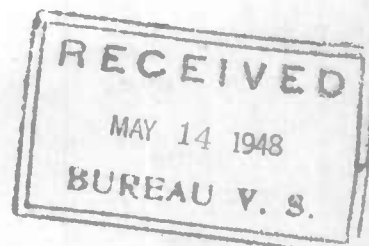
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Broschat M.D. M. D. or other

Address Washington D.C. Date signed 5-11-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH 1340

Reg. Dist. No. 216

1. PLACE OF DEATH: Montgomery  
County..... Bethesda (rural)  
City or town.....  
(If outstate city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... 9 days  
Hospital, institution or street address where death occurred:  
U. S. NAVAL HOSPITAL, Bethesda, Md.  
How long in hospital or institution?..... 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... Md. County..... P.G.  
City or town..... Rogers Heights  
(If outside city or town limits, write RURAL and give nearest town)  
Street No..... 5513 Farrogate Street  
(If rural, give LOCATION)  
2.(a) If veteran, name war..... WWI

3. (a) FULL NAME  
MC KENZIE, William Alexander

3. (b) Social Security Number

4. Sex..... Male  
5. Color or race..... W-US  
6. (a) Single, married, widowed, or divorced..... married  
6. (b) Name of husband or wife..... Agnes G. McKenzie  
6. (c) If alive, give age..... years  
7. Birth date of deceased (mo., day, yr.)..... January 2, 1885  
8. AGE: Years..... 63 Months..... 4 Days..... 4 If less than one day..... hrs. .... min.

9. Birthplace..... Washington, D. C.  
(Town, county, and state)  
10. Usual occupation..... Retired from Pulman Co.  
11. Industry or business..... Washington, D. C.  
12. Name..... McKENZIE, William dec.  
13. Birthplace..... Md.  
14. Maiden name..... CLARK, Jane Loretta  
15. Birthplace..... Md.

16. Informant..... WIFE: Mrs. Agnes G. McKenzie  
Address..... 5513 Farrogate St., Rogers Heights, Md.  
17. burial..... Date thereof..... May 10, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory..... Arlington National  
Location..... Arlington, Virginia  
18. Funeral director..... S. H. CHINESES  
Address..... 2901 14th St., N.W., Wash., D.C.  
19. 5-6-48 Mary C. Patterson  
(Date rec'd by registrar) Registrar

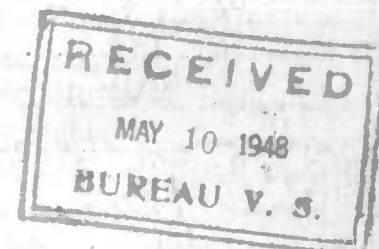
## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 6 May 48 at 4:25 A.M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
27 April 48 to 6 May 48  
and that I last saw him alive on 6 May 48

Immediate cause of death..... Acute Pylonephritis  
DURATION..... indef.  
Due to..... Renal Calculus 8 yrs.  
Due to.....  
Other conditions..... Uremia; Hypertension; Cardio vascular heart disease 8 Da, 9yrs  
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....  
Autopsy results..... confirmed above  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of.....  
Where did injury occur?..... (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury..... Injured at work?  
23. SIGNATURE..... J. T. JONES Lt JGMC USN  
Address..... USNH Bethesda, Md. Date signed..... 5-6-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 714

## 1. PLACE OF DEATH:

County MontgomeryCity or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

314 Dale Drive

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)Street No. 314 Dale Drive  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

MELVILLE MONROE MERRILL

## 3.(b) Social Security Number

577-01-1114

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married6.(b) Name of husband or wife Alice H. Merrill

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct. 2, 1877

8. AGE:

Years

Months

Days

If less than one day

7078

hrs.

min.

9. Birthplace Washington, D. C.

(Town, county, and state)

10. Usual occupation Retired11. Industry or business Telephone Co.

FATHER

12. Name Charles M. Merrill13. Birthplace Rumford, Maine

MOTHER

14. Maiden name Ina Freeman15. Birthplace Bethel, Maine16. Informant Mrs. Alice H. MerrillAddress 314 Dale Drive, Silver Spring, Md.17. Burial Date thereof May 13, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Glenwood CemeteryLocation Washington, D. C.18. Funeral director Waxner E. Pumphrey, Inc.Address 8434 Georgia Ave., Silver Spring, Md.19. May 12 1948  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1948 at 9:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 10 1944 to May 10 1948and that I last saw him alive on May 10 1948

Immediate cause of death

DURATION

Multiple cerebral emboli 10 daysDue to Generalized Arteriosclerosis 5 yrs.

Due to

Other conditions Myocardial infarction 1 month

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. B. Waidrop M.D.

M. D. or other

Address 837 Bonaparte St. Date signed May 11, 1948

RECEIVED

MAY 14 1948

BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 213

05176

### 1. PLACE OF DEATH:

County Montgo.

City or town Rock Crest Rockville MD.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgo.

City or town Rock Crest Rockville  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1019-D Beck Drive  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

SAMUEL AUSTIN MOORE

### 3. (b) Social Security Number

4. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Stella Owen

7. Birth date of deceased (mo., day, yr.) Nov. 29, 1874

6. (c) If alive, give age years

8. AGE: Years 73 Months 12 Days 1 If less than one day hrs. min.

9. Birthplace Va.  
(Town, county, and state)

10. Usual occupation Railroad Retired

11. Industry or business Eng. Southern Railroad

12. Name William A. Moore

13. Birthplace Va.

14. Maiden name Eva J. Hall

15. Birthplace Va.

16. Informant Mrs. Stella O. Moore - wife

Address Silvers Springs, Ark.

17. Removal Date thereof May 14, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory

Location 1400 Chapin St. N.W. Wash. D.C.

18. Funeral director W. H. Chambers Co.

Address 1400 Chapin St. N.W.

19. S-14 19 48 EP Shoups  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 19 48 at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 8 19 48 to May 15 19 48 and that I last saw him alive on May 14 19 48

Immediate cause of death Uremia and  
Generalized Metastasis  
Due to Carcinoma of urinary  
Bladder DURATION 4 years

Due to  
Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John S. Rosenberger M.D.  
Rockville, Maryland Date signed 5/14/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15V

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 19 1948

BUREAU V. S.

Evidence for change of  
birth date shown on:

FILE No. G 116 MAY 21 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

05177

211

1. PLACE OF DEATH:

County Montgomery  
City or town Cleagattsville Rural  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 20 years  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Montgomery  
City or town Monrovia (Rural)  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Cleagattsville  
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Mary M. Mosley

3. (b) Social Security Number

None

4. Sex Female 5. Color of face White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Walter M. Mosley

7. Birth date of deceased (mo., day, yr.) Sept 11 - 1859 (1859)

8. AGE: Years 88 Months 7 Days 4 it less than one day hrs. min.

9. Birthplace Maryland  
(Town, county, and state)

10. Usual occupation None

11. Industry or business None

12. Name Asst. M. Brown

13. Birthplace Maryland

14. Maiden name Sarah Offenberg

15. Birthplace Monrovia Rural

16. Informant Mrs. M. Mosley

17. Address Monrovia Rural

18. Burial (Burial, cremation, or removal. Which?) Burial Date thereof May 7 1948  
(month) (day) (year)

Cemetery or crematory Monrovia

Location Cleagattsville

19. Funeral director Rev. W. Barber

Address Cleagattsville

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5, 1948 at 8:05 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 3, 1948 to May 5, 1948

and that I last saw her alive on May 5, 1948

Immediate cause of death Myocardial Insufficiency

Due to Senility

Due to 2 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations none

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

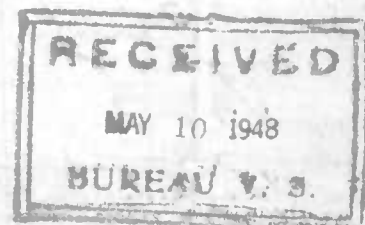
23. SIGNATURE Stanley Grabill M. D. or other

Address Mt. Airy, Md. Date signed 5/6/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

05178

47C

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 months, 18 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 2 months, 18 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Va. County Arlington  
 City or town Arlington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3004 So. 6th St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war WWI ✓

## 3. (a) FULL NAME

MURRAY, Morris Herman

## 3. (b) Social Security Number

|  |                                 |  |   |
|--|---------------------------------|--|---|
| 4. Sex<br><u>male</u>  | 5. Color or race<br><u>W-US</u> | 6. (a) Single, married, widowed, or divorced<br><u>married</u> |   |
| 6. (b) Name of husband or wife <u>Mrs. Katherine B. Murray</u>   |                                 |  |   |
| 7. Birth date of deceased (mo., day, yr.) <u>March 17, 1888</u>  |                                 |  |   |
| 6. (c) If alive, give age _____ years  |                                 |  |   |
| 8. AGE: Years<br><u>60</u>   | Months<br><u>2</u>              | Days<br><u>2</u>   | If less than one day<br>_____ hrs. _____ min. |
| 9. Birthplace <u>Delaware</u><br>(Town, county, and state)   |                                 |  |   |
| 10. Usual occupation <u>unknown</u>  |                                 |  |   |
| 11. Industry or business   |                                 |  |   |
| 12. Name <u>MURRAY, Charles W. dec.</u>  |                                 |  |   |
| 13. Birthplace <u>Delaware</u>   |                                 |  |   |
| 14. Maiden name <u>MC GONIGAL, Elvina dec.</u>   |                                 |  |   |
| 15. Birthplace <u>Pa.</u>  |                                 |  |   |
| 16. Informant <u>wife: Mrs. Katherine B. Murray</u><br>Address <u>3004 South 6th St., Arlington, Va.</u>                               |                                 |  |   |
| 17. <u>burial</u> Date thereof <u>5-24-48</u><br>(Burial, cremation, or removal. Which?) (month) (day) (year)                          |                                 |  |   |
| Cemetery or crematory <u>Arlington National</u><br><u>Arlington, Va.</u>   |                                 |  |   |
| 18. Funeral director <u>S. H. HINES</u> <u>P. J. L.</u><br>Address <u>2901 14th St., N. W., Wash. D.C.</u><br><u>Mary C. Patterson</u> |                                 |  |   |
| 19. <u>5-20</u> <u>19 48</u> <u>Mary C. Patterson</u><br>(Date rec'd by registrar) Registrar   |                                 |  |   |

## MEDICAL CERTIFICATION

20. DATE OF DEATH 19 May 19 48 at 9 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 March 19 48 to 19 May 19 48.  
 and that I last saw him alive on 19 May 19 48.

Immediate cause of death Bronchogenic Carcinoma  
with extreme cachexia and pulmonary  
edema

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury G. W. Russell Injured at work? \_\_\_\_\_  
G. W. RUSSELL, Cdr. MC USN

23. SIGNATURE \_\_\_\_\_ M. D. or other \_\_\_\_\_  
 Address USNH Bethesda, Md. Date signed 5-20-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 15 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 15 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Howard  
 City or town Clarksville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war Sp. Am.

## 3. (a) FULL NAME

MYERLY, James Richard

## 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced single  
 6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) October 27, 1874  
 8. AGE: Years 73 Months 6 Days 22 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
 (Town, county, and state)  
 10. Usual occupation Farmer  
 11. Industry or business \_\_\_\_\_  
 12. Name MYERLY, John J.  
 13. Birthplace Md.  
 14. Maiden name OWENS, Harriet  
 15. Birthplace Md.

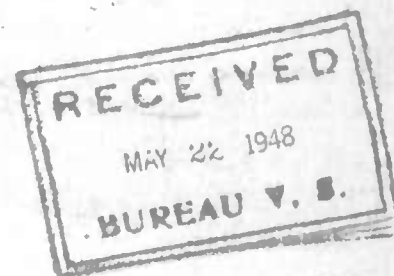
16. Informant brother: Mr. William F. Myerly  
 Address Simpsonville, Clarksville Post Office, Md.  
 17. burial Date thereof 5-22-48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory St. Marks  
 Location Highland, Md.  
 18. Funeral director Higinbotham Funeral Home  
 Address Elliott City, Howard County, Md.  
5-19 48 Mary C. Patterson  
 (Date rec'd by registrar) 19. \_\_\_\_\_ Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 19 May 19 48 at 9:25 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4 May 19 48 to 19 May 19 48  
 and that I last saw him alive on 19 May 19 48  
 Immediate cause of death Cerebral Hemorrhage DURATION \_\_\_\_\_

Due to Arteriosclerosis  
Hypertension  
 Due to \_\_\_\_\_  
 Other conditions Bronchopneumonia  
Cystitis  
 (Include pregnancy within 8 months of death)  
 Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results confirmed above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE Charles Savage  
Charles SAVAGE, Lt JG MC USN  
USNH Bethesda, Md. M. D. or other 5-19-48  
 Date signed \_\_\_\_\_





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

05180

1068

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10 days  
 Hospital, institution, or street address where death occurred:  
U. S. NAVAL HOSPITAL, Bethesda, Md.  
 How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State La. County \_\_\_\_\_  
 City or town Alexandria  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1128 8th St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

OVERTON, John Holmes, Senator

## 3.(b) Social Security Number

4. Sex Male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced MARRIED  
 6.(b) Name of husband or wife Ruth D. Overton  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) September 17, 1875  
 8. AGE: Years 72 Months 7 Days 17 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Malksville, La.  
 (Town, county, and state)  
 10. Usual occupation Senator  
 11. Industry or business \_\_\_\_\_  
 12. Name OVERTON, Thomas dec. \_\_\_\_\_  
 13. Birthplace La.  
 14. Maiden name WADILL, Laura dec. \_\_\_\_\_  
 15. Birthplace La.

16. Informant wife: Mrs. Ruth D. Overton  
 Address Wardman Park Hote, Washington, D. C.  
 17. burial Removal Date thereof May 14, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory \_\_\_\_\_  
 Location Alexandria, La.  
 18. Funeral director Joseph Gawler  
 Address 1750 Penn. Ave., N.W., Wash., D.C.  
Mary C. Patterson  
 19. 5-14-48  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 14 May 19 48 at 5:50 A.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4 May 19 48 to 14 May 19 48  
 and that I last saw h. im alive on 14 May 19 48

Immediate cause of death Acute Myocardial Failure DURATION immediate  
 Due to \_\_\_\_\_  
 Due to Diverticulosis of large intestine 2 yrs.  
 Other conditions Diverticulitis of large intestine 12da.  
Bronchiectasis several yrs.  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results Confirmed above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

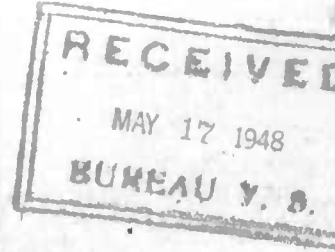
22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE W. F. Harrison, Jr. M. D. or other \_\_\_\_\_  
W. F. Harrison, Jr., Lt. MC. USN  
 Address USNH Bethesda, Md. Date signed 5-14-48

VS A15

9-45-15

MARGIN RESERVED FOR BIND

I



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of the person or place mentioned should be given. Please write the cause of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05181

Reg. Dist. No. 216

### 1. PLACE OF DEATH:

County... Montgomery

City or town... Bethesda  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days

Hospital, institution, or street address where death occurred:

U.S.N. Hospital, Bethesda, Md.

How long in hospital or institution? 10 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... District Columbia

City or town... Washington  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1446 Belmont St. N.W.  
(If rural, give LOCATION)

2.(a) If veteran, name war... ☒

### 3. (a) FULL NAME

Garnet A.

5. Color or race

Negro

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife Mrs. Corean Owens

6.(c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) 9 April 1896

| 8. AGE: | Years     | Months   | Days      | If less than one day |
|---------|-----------|----------|-----------|----------------------|
|         | <u>52</u> | <u>1</u> | <u>22</u> | hrs. min.            |

9. Birthplace Riverdale, Virginia  
(Town, county, and state)

10. Usual occupation Independent Gardener

11. Industry or business

12. Name unknown

13. Birthplace unknown

14. Maiden name unknown

15. Birthplace unknown

16. Informant Wife: Mrs. Corean Owens

Address 1446 Belmont St., N. W., Wash., D.C.

17. burial Date thereof 6-4-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington, Va.

18. Funeral director W. Ernest Jarvis

Address 1432 U St., N. W., Wash., D.C.

19. 5-31 19 48 Mary C. Patterson  
(Date rec'd by registrar) Registrar

### 3. (b) Social Security Number

### MEDICAL CERTIFICATION

2D. DATE OF DEATH May 31 19 48 at 5:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Def med. Exam case 19 48 to 19 48  
and that I last saw h... alive on 19 48

Immediate cause of death

Inter cranial hemorrhage 10 days

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 5/31/48

Where did injury occur? Washington DC  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Street

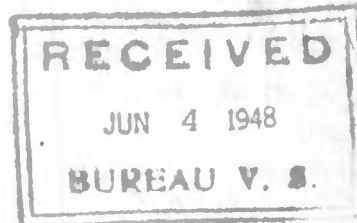
Means of injury Struck by Taxi Injured at work? No

Frank J. Brosnack M.D.

23. SIGNATURE Def med. Exam M. D. or other

Address Washington MD Date signed 5/31/48

Body referred to Dr. Corner  
Frank J. Biscant M.D.  
Dep Med Exams.  
Washington, D.C.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 213

05182

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Rockville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 21 Years  
 Hospital, institution, or street address where death occurred:  
Home - 112 Forest Ave., Rockville, Md.  
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Rockville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 112 Forest Avenue,  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war No

## 3. (a) FULL NAME

Henry Kay Pasma

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Olive L.

7. Birth date of deceased (mo., day, yr.) May 29, 1880 8. (c) If alive, give age 60 years

8. AGE: Years 67 Months 67 Days 11 If less than one day 15 hrs. min.

9. Birthplace Holland  
(Town, county, and state)10. Usual occupation Minister

11. Industry or business

12. Name Klaas Pasma13. Birthplace Holland14. Maiden name Clara Nauta15. Birthplace Holland16. Informant Mrs. Olive PasmaAddress 112 Forest Ave., Rockville, Md.17. Burial Date thereof May 17-1948  
(Burial, cremation, or removal. Which?) (Month) (day) (year)Cemetery or crematory Rockville Union CemeteryLocation Rockville - Montg. Co.18. Funeral director Wm. Paul MurphyAddress Bethesda, Maryland19. 5/17/48 19 E.P. Thompson  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 14, 19 48, at 3:00p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1944 to May 14 19 48  
 and that I last saw him alive on May 13 19 48

Immediate cause of death

Stokes Adams Syncope -Due to Coronary Heart Disease 37 years

Due to

Other conditions diabetes 37 years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Webb M. D. or otherAddress Rockville - Date signed 5/17/48

RECEIVED

MAY 19 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH 159

05183

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution?

10 hours

## 3. (a) FULL NAME

Infant Boy Pounds

## 3. (b) Social Security Number

4. Sex

male

5. Color or race

white new-born

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

May 28, 1948

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

10 hours

hrs.

min.

9. Birthplace

Bethesda, Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

Gavin Aubrey Pounds

13. Birthplace

Prichard, Alabama

MOTHER

14. Maiden name

Betty Paves

15. Birthplace

Rochester, Minn.

16. Informant

Gavin Aubrey Pounds

Address

4119 W. St. N.W. D.C.17. Cremation

(Burial, cremation, or removal. Which?)

Date thereof

June 1, 1948

(month) (day) (year)

Cemetery or crematory

Cedar Hill Cemetery

Location

Suitland, Maryland

18. Funeral director

Wm. Reuben Humphrey

Address

Bethesda, Maryland

19.

5/31/48

(Date rec'd by registrar)

Wm E Jones

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Washington D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

4119 W St. N.W.

(If rural, give LOCATION)

2. (a) If veteran, name war

✓

## MEDICAL CERTIFICATION

20. DATE OF DEATH

May 28 - 48 at 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5/281948

to

5/281948

and that I last saw him alive on

5/281948

Immediate cause of death

Prematurely - 6 months

DURATION

10 hours

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Brue T. Benjamin

M. D. or other

Address

Bethesda, MdDate signed 5/29/48

RECEIVED  
JUN 3 1948  
BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05184

69

223

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Fifteen days

Hospital, institution, or street address where death occurred:

Washington Sanitarium and HospitalHow long in hospital or institution? Fifteen days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia County .....City or town Morrisville  
(If outside city or town limits, write RURAL and give nearest town)Street No. ....  
(If rural, give LOCATION)

2.(a) If veteran, name war ..... ✓

## 3. (a) FULL NAME

Jesse Bucher Price

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

Cauc.

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Mrs. Geneva A. Price7. Birth date of deceased (mo., day, yr.) Sept. 3, 18816. (c) If alive, give age 61 years

## 8. AGE:

Years

Months

Days

If less than one day

66814

hrs.

min.

9. Birthplace Highland Co., Virginia  
(Town, county, and state)10. Usual occupation Farmer

## 11. Industry or business

MOTHER FATHER

12. Name Ambrose Price13. Birthplace Highland Co., Va.14. Maiden name Martha Rummisell15. Birthplace Highland Co., Va.16. Informant Mrs. Carl KeckhnAddress Dexter, Michigan17. Removal  
(Burial, cremation, or removal. Which?)Date thereof May 27, 1948  
(month) (day) (year)

Cemetery or crematory

Location Fredricksburg, Virginia

18. Funeral director

Address Alexandria, Virginia19. May 27, 1948  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1948 10:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 12 1948 to May 27 1948and that I last saw him alive on May 27 1948

Immediate cause of death

PneumoniaDue to Acute PulmonaryDue to Acute PneumoniaPemphigus

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. ....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. .... Date of .....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE

Dr. J. H. Price

M. D. or other

Address Takoma Park, Md. Date signed 5-27-48

RECEIVED

MAY 31 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The birth age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05185

93d

Reg. Dist. No. 211

## 1. PLACE OF DEATH:

County Montgomery  
 City or town En route to north. County General Hospital  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 years  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Damascus  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2. (a) If veteran, name War \_\_\_\_\_

## 3. (a) FULL NAME

Ida Dorcas Rhinehart

## 3. (b) Social Security Number

—

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

married

8. (b) Name of husband or wife

Rezie W. Rhinehart

7. Birth date of deceased (mo., day, yr.)

Jan. 30, 19066. (c) If alive, give age 41 years

8. AGE:

Years

Months

Days

If less than one day

4238

hrs.

min.

9. Birthplace

West Virginia  
(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

Home

MOTHER FATHER

12. Name

James Whitely

13. Birthplace

West Virginia

14. Maiden name

Unknown

15. Birthplace

16. Informant

Husband

Address

Damascus, Maryland

17.

Burial  
(Burial, cremation, or removal, Which?)

Date thereof

May 10, 1948  
(month) (day) (year)

Cemetery or crematory

Damascus, Md

Location

Damascus, Md

18. Funeral director

J. B. Beall, Inc.

Address

Damascus, Md.

19.

May 8  
(Date rec'd by registrar)

19.

48 Della K. Burdette  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

May 8

19

48 3:00 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 4,

19

48 to May 8

19

and that I last saw him/her alive on

May 7,

19

Immediate cause of death Hypertensive cardio-vascular disease.

DURATION

1 monthDue to and Pulmonary edema

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide \_\_\_\_\_

Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

23. SIGNATURE

James P. Kerr M.D.

M. D. or other

Address

Damascus, Md.

Date signed

5/10/48

RECEIVED

MAY 13 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05186

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda, (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 month, 15 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 1 month, 15 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State D.C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1711 9th St., N. W.  
 (If rural, give LOCATION)  
WWI ✓  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Charles Grant Richardson

## 3. (b) Social Security Number

4. Sex Male 5. Color or race Negro 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Inez Richardson  
 7. Birth date of deceased (mo., day, yr.) April 27, 1892 6.(c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 56 Months 1 Days 4 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
 (Town, county, and state)  
 10. Usual occupation Porter  
 11. Industry or business \_\_\_\_\_  
 12. Name RICHARDSON, Charles dec. \_\_\_\_\_  
 13. Birthplace Md.  
 14. Maiden name SNELL, Emma  
 15. Birthplace Md.

16. Informant wife: Mrs. Inez Richardson  
 Address 1711 9th St., N. W., Wash., D.C.  
 17. burial Date thereof 6-3-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Arlington National Cemetery  
 Location Arlington, Virginia  
 18. Funeral director m.u. Henry S. Washington, & Sons.  
 Address 467 "N" N.W., Washington, D.C.  
Mary C. Patterson  
 19. 5-31- 48 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 31 May 19 48 at 9:35 AM  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 16 April 19 48 to 31 May 19 48  
 and that I last saw him alive on 31 May 19 48  
 Immediate cause of death Nephritis, Chronic DURATION indef.  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions Hypertension Arterial indef.  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results no autopsy  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.  
 22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE L. E. WATTERS, Jr., Lt. JG MC USN M. D. or other \_\_\_\_\_  
USNH Bethesda, Md. Address \_\_\_\_\_ Date signed 5-31-48

RECEIVED

JUN 3 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County..... Montgomery  
 City or town..... Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 5 days  
 Hospital, institution, or street address where death occurred:  
U. S. NAVAL HOSPITAL, Bethesda, Md.  
 How long in hospital or institution?..... 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Md. County.....  
 City or town..... Montgomery  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... Chevy Chase,  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war..... 25 Grafton St.

## 3. (a) FULL NAME

ROBBINS, Alfred Perkins

## 3. (b) Social Security Number

4. Sex..... Male  
 5. Color or race..... W-US  
 6. (a) Single, married, widowed, or divorced..... married

6. (b) Name of husband or wife..... Carrie C. Robbins

7. Birth date of deceased (mo., day, yr.)..... October 7, 1866  
 8. (c) If alive, give age..... years

8. AGE: Years..... 81 Months..... 7 Days..... 4  
 If less than one day..... hrs. .... min.

9. Birthplace..... Washington, D. C.  
(Town, county, and state)10. Usual occupation..... unemployed

11. Industry or business

12. Name..... ROBBINS, Nathaniel Augustus dec.  
 13. Birthplace..... Maine

14. Maiden name..... PERKINS, Letitia M. dec.  
 15. Birthplace..... Maine

16. Informant..... wife: Mrs. Carrie D. Robbins  
 Address..... 25 Grafton St., Chevy Chase, Md.

17. burial Date thereof..... 5-14-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Arlington National  
 Location..... Arlington, Va.

18. Funeral director..... S. H. HINES & Co.  
 Address..... 2901 14th St., N. W., Washington, D. C.

19. 5-12-48 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 11 May 19 48, at 9:40 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
6 May 19 48, to 11 May 19 48  
 and that I last saw him alive on 11 May 19 48

Immediate cause of death..... Cerebral Thrombosis DURATION..... 5 days +

Due to..... arteriosclerosis, Cerebral & general undef.  
 Due to..... undef.

Other conditions..... Hypertension,  
arterial  
 (Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results..... not obtained Date of op. ....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... F. E. WEITZEL Lt MC USN  
 M. D. or other

Address..... USNH Bethesda, Md. Date signed..... 5-12-48

RECEIVED

MAY 13 1948

BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05189

Reg. Dist. No. 714

## 1. PLACE OF DEATH:

County MontgomeryCity or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

11,702 Georgia Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)Street No. 11,702 Georgia Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

E. Roy Routt

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Esther Rae Routt

7. Birth date of

deceased (mo., day, yr.)

Nov. 8, 1886

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

It less than one day

61611

hrs.

min.

9. Birthplace

Nr. Warrenton, Va.

(Town, county, and state)

10. Usual occupation

Horse trainer

11. Industry or business

MOTHER FATHER

12. Name

Alfonso Routt

13. Birthplace

Warrenton, Va.

14. Maiden name

Caroline Helflin

15. Birthplace

Warrenton, Va.

16. Informant

Randolph J. Routt

Address

303 Lexington Dr. Silver Spring

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

May 21, 1948

(month) (day) (year)

Cemetery or crematory

Rock Creek

Location

Washington, D.C.

18. Funeral director

Warner E. Humphrey, Inc.

Address

8434 Ga. Ave. Silver Spring, Md.

19.

May 20 1948  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1948 at 12:02 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep Med Exam done 19 19  
and that I last saw h. alive on 19 19

Immediate cause of death

DURATION

Coronary occlusionsudden

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank J. Bruchart M.D.

M. D. or other

Address

Yardleyburg Md. Date signed 5-19-48

RECEIVED  
MAY 21 1948  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05190

Reg. Dist. No. *218*

1. PLACE OF DEATH: *Montg Co,*  
County.....  
City or town..... *Gaithersburg Md. (Rural)*  
(If outside city or town limits, write RURAL and give nearest town)  
*18yrs*  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
  
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... *Md.* County..... *Montgomery*  
City or town..... *Washington Grove*  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

3. (a) FULL NAME  
*Clinton Conrad Royer*

3. (b) Social Security Number

4. Sex..... *Male* 5. Color or race..... *White* 6.(a) Single, married, widowed, or divorced..... *Married*  
6.(b) Name of husband or wife..... *Mary Z. Royer*  
6.(c) If alive, give age..... *68* years  
7. Birth date of deceased (mo., day, yr.)..... *Feb 12th 1878*  
8. AGE: Years..... *70* Months..... *2* Days..... *25* If less than one day..... hrs. .... min.

9. Birthplace..... *Montg Co, Md.*  
(Town, county, and state)  
10. Usual occupation..... *Retired Farmer*  
11. Industry or business.....  
12. Name..... *Conrad Royer*  
13. Birthplace..... *Md.*  
14. Maiden name..... *Lavenia Belt*  
15. Birthplace..... *Md.*

16. Informant..... *Mrs Mary Z Royer*  
Address..... *Gaithersburg Md,*  
17. *Burial* Date thereof..... *5/10/48*  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory..... *Mt Olivet Cemetery*  
*Frederick Md,*  
Location.....  
18. Funeral director..... *Ernest C Gartner*  
Address..... *Gaithersburg Md,*  
19. *May 9 48 Rhoda G. G. G. G.*  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... *May - 7 -* 19*48* at *7:30* P M  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *March - 24* 19*48* to *May - 7 -* 19*48*  
and that I last saw him alive on *May - 7 -* 19*48*  
Immediate cause of death..... *Cerebral hemorrhage*  
Due to..... *arterio-sclerosis*  
Due to.....  
Other conditions.....  
(Include pregnancy within 3 months of death)

DURATION  
*6 days*

Major findings of operations.....  
Date of op.....  
Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of.....  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?  
23. SIGNATURE..... *William C. Miller, M.D.*  
Gaithersburg Md  
Date signed..... *5/8/48*

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

RECEIVED

MAY 12 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County MONTGOMERYCity or town Bethesda Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? SINCE MAY 7 '48 5:30 P.M.Hospital, institution, or street address where death occurred: SUBURBAN HOSP.  
8600 OLD GEORGETOWN RD. Bethesda, Md.How long in hospital or institution? SINCE MAY 7 '48 5:30 P.M.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County MONTGOMERYCity or town SILVER SPRING  
(If outside city or town limits, write RURAL and give nearest town)Street No. 907 Spring St.  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

AUGUST W. Schickler

## 3. (b) Social Security Number

## 4. Sex

M

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife.....

## 7. Birth date of deceased (mo., day, yr.)

JANUARY 4, 1895

## 6. (c) If alive, give age..... years

## 8. AGE:

Years

Months

Days

If less than one day

6347

hrs.

min.

## 9. Birthplace.....

Washington, D.C.  
(Town, county, and state)

## 10. Usual occupation.....

Unemployed

## 11. Industry or business.....

FATHER  
MOTHER

## 12. Name.....

ANDREW Schickler

## 13. Birthplace.....

GERMANY

## 14. Maiden name.....

CATHERINE Scheuch

## 15. Birthplace.....

Washington, D.C.

## 16. Informant.....

Hospital Records

## Address.....

## 17.

Cremation  
(Burial, cremation, or removal. Which?)

## Date thereof.....

5/13/48  
(month) (day) (year)

## Cemetery or crematory.....

FA Lincoln

## Location.....

## 18. Funeral director.....

St. John's Co.

## Address.....

2901-14<sup>th</sup> Street N.W. Washington, D.C.

## 19.

5/11  
(Date rec'd by registrar)

19.

4876 m & John

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 11 1948, at 6:00 am

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1947, to May 11 1948  
and that last saw him alive on May 10 1948

## Immediate cause of death.....

Myocardial insufficiency

## DURATION

1 year

## Due to.....

Arteriosclerotic & Hypertensive  
Heart Disease10 years

## Due to.....

## Other conditions.....

(Include pregnancy within 3 months of death)

## Major findings of operations.....

No operations

## Autopsy results.....

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

## 23. SIGNATURE.....

Baron H. Traub M.D.

M. D. or other

Address 8237 Georgetown Silver Spring Rd Date signed 5/11-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 20 1948

BUREAU V. S.

Evidence for change of  
age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05192

Form No. G 116 JUN 10 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH:

County Montgomery  
City or town Rural Littlefield road  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? ten years  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
City or town Rural Monrovia road  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

3. (a) FULL NAME

Samuel S. Shiffer

3. (b) Social Security Number

1

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) Oct 25 - 1860  
8. AGE: Years 87 (87) Months 6 Days 29 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
(Town, county, and state)

10. Usual occupation Stone mason

11. Industry or business Stone + Brick

12. Name John R. Shiffer

13. Birthplace Maryland

14. Maiden name May Ellen Snowden

15. Birthplace Maryland

16. Informant Mrs. Adeline E. Watkins

Address Monrovia road

17. Burial Date thereof May 27 - 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bethesda

Location Browningville road

18. Funeral director Ray W. Barber

Address Laytonville road

19. May 26 1948 Della W. Burdette  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH May 24, 1948 at 11:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 18, 1947 to May 24, 1948 and that I last saw him alive on May 20, 1948

Immediate cause of death arteriosclerotic  
cardio-vascular disease.

and cerebral thrombosis, right 15 years  
DUE TO \_\_\_\_\_ DURATION \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE James P. Kerr M.D.

M. D. or other

Address \_\_\_\_\_ Date signed \_\_\_\_\_

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**

MAY 28 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05188

Reg. Dist. No. 218

1. PLACE OF DEATH: Montg Co  
 County.....  
 City or town..... Derwood. (Rural) Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 3 yrs  
 Hospital, institution, or street address where death occurred:  
 .....  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... Maryland County..... Montg.  
 City or town..... Redland. Derwood, Rural,  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Robert Harvey Shreve

## 3. (b) Social Security Number

4. Sex..... Male  
 5. Color or race..... White  
 6.(a) Single, married, widowed, or divorced..... Widower  
 6.(b) Name of husband or wife..... Lottie M Loenz  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... April 8th 1983  
 8. AGE: Years..... 65 Months..... 1 Days..... 2 If less than one day..... hrs. .... min.

9. Birthplace..... Harrisburg W Va  
 (Town, county, and state)  
 10. Usual occupation..... Ret. Plaster  
 11. Industry or business.....

12. Name..... Joshaway Shreve  
 13. Birthplace..... W.Va.,  
 14. Maiden name..... Mary S.  
 15. Birthplace..... W.Va.,  
 16. Informant..... Mrs Pauline Liller  
 Address..... Derwood Md.,

17. Burial..... Date thereof..... 5/13/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Forest Oak Cemetery  
 Location..... Gaithersburg Md.  
 18. Funeral director..... Ernest C Gartner  
 Address..... Gaithersburg Md.,

19. May 12 1948.....  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 10th 1948 at 8.45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/17 1948, to May 10 1948 and that I last saw him alive on May 10 1948

Immediate cause of death..... Chronic Myocarditis

Due to.....

Due to.....

Other conditions..... Chronic Nephritis  
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?

23. SIGNATURE..... C.E. Harrowes.  
 M. D. or other.....  
 Address..... Potomac Md.  
 Date signed..... 5/14/48

RECEIVED

MAY 17 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05193

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban Hospital  
8 hours

How long in hospital or institution?

## 3. (a) FULL NAME

Abram B. Simon

## 3. (b) Social Security Number

None

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Edna Simon

## 7. Birth date of deceased (mo., day, yr.)

July 29, 1866

## 6. (c) If alive, give age..... years

## 8. AGE:

Years 81Months 10

Days

If less than one day

hrs.

min.

## 9. Birthplace

Philadelphia, Pennsylvania  
(Town, county, and state)

## 10. Usual occupation

Pennsylvania Railroad

## 11. Industry or business

FATHER  
MOTHER

## 12. Name

Abram Simon

## 13. Birthplace

Mont. Co., Pa.

## 14. Maiden name

Susanna Clayton

## 15. Birthplace

Mont. Co., Pa.

## 16. Informant

Daughter, Mrs. Norris Justice

## Address

7803 Georgetown Rd. Bethesda

## 17. Removal

(Burial, cremation, or removal. Which?)

## Date thereof

May 29, 1948  
(month) (day) (year)

## Cemetery or crematory

Philadelphia, Pennsylvania

## Location

## 18. Funeral director

## Address

Wm. Reuben Cunningham  
Bethesda, Maryland

## 19.

5/31  
(Date rec'd by registrar)1948Wm B. J. J. J.  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty MontgomeryCity or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

Street No. 7803 Georgetown Rd.

(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

May 291948at 340  
A. M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1946, to May 1948and that I last saw Jan alive on May 24th 1948

## Immediate cause of death

Acute Congestive Heart Failure

## DURATION

3 days

## Due to

Renal and Arteriosclerosis

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

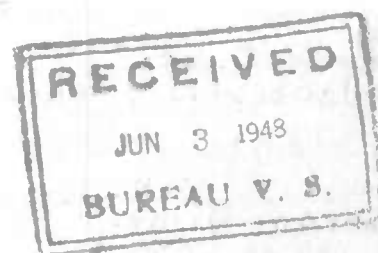
Means of injury

Injured at work?

## 23. SIGNATURE

M. D. or other

Address 8016 Dwight BlvdDate signed 5/29/48



Evidence for change of  
age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05194

FILM No. G 116 MAY 24 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County Montgomery

City or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:  
104 Dale Drive

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 104 Dale Drive  
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Willard R. Smallwood

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife Doralee A.

7. Birth date of deceased (mo., day, yr.) March 14, 1888

8. (c) If alive, give age years

8. AGE: Years 60 Months 2 Days 26 If less than one day  
hrs. min.

9. Birthplace Maryland  
(Town, county, and state)

10. Usual occupation Contractor

11. Industry or business Roads, streets, etc.

12. Name Phillip Smallwood

13. Birthplace Maryland.

14. Maiden name Emma Parker

15. Birthplace Maryland

16. Informant Mrs Doralee A. Smallwood

Address 104 Dale Dr. Silver Spring

17. Burial Date thereof May 20, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Mark's Church

Location Highland, Howard Co. Md.

18. Funeral director Waxner E. Pumphrey Inc.

Address 8434 Ga. Ave., Silver Spring, Md.

19. May 19 19 48 Joeshine M. Schaeffer  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 19 48 at 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
May 13 19 48 to May 18 19 48

and that I last saw him alive on May 18 19 48

Immediate cause of death Coronary thrombosis

DURATION  
4 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank A. Zick M.D.

Address 8248 Ga. Ave. Silver Spring Md. Date signed 5-19-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County... Montgomery  
 City or town... Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 months, 1 day  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 3 months, 1 day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Virginia County...  
 City or town... Norfolk  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 8222 Gyax Road, Oakdale Farm  
 (If rural, give LOCATION)  
 2.(a) If veteran, name War

## 3. (a) FULL NAME

WOOD, Thelma Lorraine

## 3. (b) Social Security Number

4. Sex female 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife... James B. Wood, CMM USN

7. Birth date of deceased (mo., day, yr.) August 19, 1908 8. (c) If alive, give age... years

8. AGE: Years 39 Months 9 Days 3 If less than one day... hrs. min.

9. Birthplace... Maryland  
 (Town, county, and state)

10. Usual occupation... housewife

11. Industry or business

12. Name... KIPER, Richard dec.13. Birthplace... Okla.14. Maiden name... GORDON, Izetta dec.15. Birthplace... Va.16. Informant... husband: James B. Wood, CMM USNAddress... USS TARAWA, San Francisco, Calif.

17. burial Date thereof... 5-25-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Arlington NationalLocation... Arlington, Virginia18. Funeral director... WARNER PUMPHREY WEPAddress... 8434 Georgia Ave. Silver Springs, Md.

19. 5-22 19 48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... 22 May 19 48 at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
21 February 19 48 to 22 May 19 48  
 and that I last saw h. Dr alive on 22 May 19 48

Immediate cause of death... Peritonitis generalized DURATION 1 wk.

Due to... post operative

Due to...

Other conditions... Convulsions + coma 11 days

(Include pregnancy within 3 months of death)

Major findings of operations... extensive adhering small bowel Date of op. 5/11/48

Autopsy results... ex. peritonitis  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Joseph J. Zusta Joseph J. Zusta, Cdr. MC USN

23. SIGNATURE... Joseph J. Zusta M. D. or other

Address... USNH Bethesda, Md. Date signed... 5-22-48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 218

## 1. PLACE OF DEATH:

County Montgomery  
Bethesda (rural)  
 City or town (If outside city or town limits, write RURAL and give nearest town)  
24 days  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
U. S. NAVAL HOSPITAL, Bethesda, Md.  
24 days  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Washington, D. C. County  
 City or town (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 937 Mass., Avenue, N.W.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

WILLIAMS, Allen George

## 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Mrs. Ruth Williams  
 7. Birth date of deceased (mo., day, yr.) June 14, 1905 6. (c) If alive, give age years  
 8. AGE: Years 42 Months 11 Days 13 If less than one day hrs. min.

9. Birthplace W. Va. (Town, county, and state)  
 10. Usual occupation unemployed  
 11. Industry or business  
 12. Name WILLIAMS, Thomas dec.  
 13. Birthplace Va.  
 14. Maiden name CRUISE, Nannie  
 15. Birthplace Va.

16. Informant wife: Mrs. Ruth Williams  
 Address 937 Mass. Ave., N. W., Washington, D. C.  
 17. burial Date thereof 5-28-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
Arlington National Cemetery  
 Cemetery or crematory  
Arlington, Va.  
 Location

18. Funeral director W. W. CHAMBERS  
 Address 1400 Chapin St., N.W., Wash. D. C.  
 19. 5-27 48  
 (Date rec'd by registrar) Mary C. Patterson Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 27 May 19 48 21 3:19A M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3 May 19 48 to 27 May 19 48  
 and that I last saw him alive on 27 May 19 48

Immediate cause of death  
Tumor, Mixed, Malignant, Brain

## DURATION

Due to  
 Due to  
 Other conditions Broncho pneumonia

(Include pregnancy within 3 months of death)

Major findings of operations Brain Tumor, lt. temporo parietal  
Multiform Glioblastoma Date of op. January 1948

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE W. J. James  
W. J. JAMES, Cdr. MC USN or other  
 Address USNH Bethesda, Md. Date signed 5-27-48

RECEIVED

MAY 28 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 days  
Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
How long in hospital or institution? 2 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Albany  
City or town Indian Head  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 15 Jonqual St.  
(If rural, give LOCATION)  
2.(a) If veteran, name war ☒

### 3. (a) FULL NAME

WEISS, Baby Boy MICHAEL PAUL

### 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced single  
6.(b) Name of husband or wife  
6.(c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) May 10, 1948  
8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 2 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Bethesda, Maryland (rural)  
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name WEISS, Stephen Joseph

13. Birthplace Philadelphia, Pa.

MOTHER 14. Maiden name COOK, Elva Mary

15. Birthplace Australia

16. Informant Father: Stephen Joseph Weiss

Address 15 Jonqual St., Indian Head, Md.

17. burial Date thereof 5-14-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington, Va.

18. Funeral director W. W. CHAMBERS

Address Georgetown, D.C.

5-13 48 Mary G. Patterson  
19. (Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 12 May 19 48 at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 May 19 48 to 12 May 19 48  
and that I last saw him alive on 12 May 19 48

Immediate cause of death Intracranial Hemorrhage and Atelectasis  
DURATION 2 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE PAUL PETERSON, Capt. MC USN  
USNH Bethesda, Md. M. D. or other 5-13-48

Address Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 18 1948

BUREAU V. S.

Evidence for change of age is shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: **Montgomery**  
County **Bethesda (rural)**  
City or town (If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? **1 day**  
Hospital, institution, or street address where death occurred:  
**U. S. NAVAL HOSPITAL, Bethesda, Md.**  
How long in hospital or institution? **1 day**

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State **Washington, D. C.** County  
City or town (If outside city or town limits, write RURAL and give nearest town)  
Street No. **824 Eye St., N. E.**  
(If rural, give LOCATION)  
2. (a) If veteran, name war **Sp. Am.**

3. (a) FULL NAME

**Eugene Dale SMITH**

3. (b) Social Security Number

4. Sex **Male** 5. Color or race **W-US** 6. (a) Single, married, widowed, or divorced **married**  
6. (b) Name of husband or wife **Mary T. Smith**  
6. (c) If alive, give age years  
7. Birth date of deceased (mo., day, yr.) **August 26, 1873**  
8. AGE: Years **74** Months **8** Days **19** If less than one day hrs. min.

9. Birthplace **Virginia** (Town, county, and state)  
10. Usual occupation **Hot Water Heater Contractor**  
11. Industry or business **(retired)**  
12. Name **SMITH, William** dec.  
13. Birthplace **Va.**  
14. Maiden name **CHEWNING, Elizabeth** dec.  
15. Birthplace **Va.**

16. Informant **wife: Mrs. Mary T. Smith**  
Address **824 Eye St., N. E., Wash., D.C.**  
17. **burial** Date thereof **5-18-48**  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory **Ft. Lincoln**  
Location **Washington, D. C.**  
18. Funeral director **DEAL FUNERAL HOME** **R. E. Widel**  
Address **816 H Street, NE, Wash. D.C.**  
**Mary C. Patterson**  
19. **5-15** 19 **48** **Mary C. Patterson**  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **15 May** 19 **48** at **1:30 P.M.**  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **14 May** 19 **48** to **15 May** 19 **48**  
and that I last saw him alive on **15 May** 19 **48**

Immediate cause of death **Central Hemorrhage**  
**Hypertension**  
**Atherosclerosis**  
Due to **3 yrs.**  
**5 yrs.**  
Due to **amputation, bilateral legs.** **1 year**  
(Include pregnancy within 3 months of death)

Major findings of operations  
Autopsy results **confirmed above**  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury **Wade H. Boswell** Injured at work?  
23. SIGNATURE **W. H. BOSWELL, Lt MC USN**  
**USNH Bethesda, Md.** M. D. or other  
Date signed **5-15-48**

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 18 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05196

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 27 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 27 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State W.Va. County \_\_\_\_\_  
 City or town Charleston  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 879 Chester Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war WWI

## 3. (a) FULL NAME

SMITH, Everett Clare

## 3. (b) Social Security Number

## 4. Sex

male

## 5. Color or race

W-US

## 6. (a) Single, married, widowed, or divorced

married

## 6. (b) Name of husband or wife

Jannet M. Smith

## 7. Birth date of deceased (mo., day, yr.)

November 7, 1885

## 6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

62

Months

6

Days

9

If less than one day

hrs.

min.

## 9. Birthplace

W.Va.

(Town, county, and state)

## 10. Usual occupation

Sp. Assist. to Asst. Administrator

## 11. Industry or business

Veterans Administration

## FATHER

12. Name SMITH, Everett dec

## 13. Birthplace

W.Va.

## MOTHER

14. Maiden name WRIGHT, Harriot dec

## 15. Birthplace

Pa.

## 16. Informant

wife: Mrs. Jannet M. Smith

## Address

879 Chester Road, Charleston, W.Va.

## 17.

burial Removal Date thereof May 17, 1948

(Burial, cremation, or removal, which?)

(month) (day) (year)

## Cemetery or crematory

Ravenswood Cemetery

## Location

Ravenswood, W.Va.

## 18. Funeral director

W. W. CHAMBERS

## Address

1400 Chapin St., N. W., Wash., D.C.

## 19.

5-17 19 48

(Date rec'd by registrar)

Mary C. Patterson  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 16 May 19 48 at 7:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 April 19 48 to 16 May 19 48and that I last saw him alive on 16 May 19 48

Immediate cause of death

Subacute Bacterial Endocarditis

DURATION

1 Apr. 48

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury

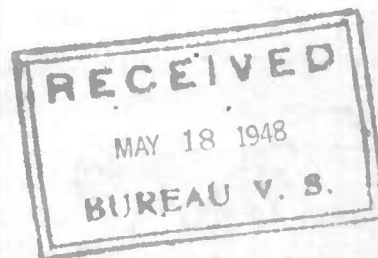
Injured at work?

23. SIGNATURE

T. E. JARRETT, Cdr., MC USN  
USNH Bethesda, Md.

M. D. or other

Address \_\_\_\_\_ Date signed 5-17-48

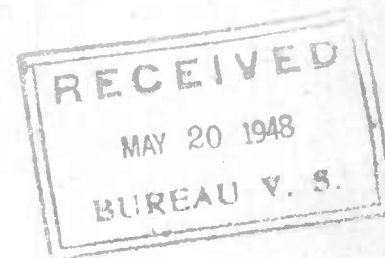




Address..... 1000 1st St. N. W. Date signed 5-10-48

VS A15 9-45-15M

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





RECEIVED

MAY 13 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Evidence for change of

age shown on:

FILM NO. G 116 JUN -2 1948

## CERTIFICATE OF DEATH

05199

Reg. Dist. No. 211

## 1. PLACE OF DEATH:

County MontgomeryCity or town near Damascus Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town near Damascus  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Joseph Thomas Underwood

## 3. (b) Social Security Number

## 4. Sex

male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

married

## 6. (b) Name of husband or wife

Ola Waddell Underwood6. (c) If alive, give age 40 years

## 7. Birth date of deceased (mo., day, yr.)

may 5-1886

## 8. AGE:

Years

Months

Days

If less than one day

52-8

hrs.

min.

## 9. Birthplace

Concord Tennessee  
(Town, county, and state)

## 10. Usual occupation

Laborer

## 11. Industry or business

FATHER  
MOTHER

## 12. Name

George Underwood

## 13. Birthplace

Tennessee

## 14. Maiden name

Audoria Ruby

## 15. Birthplace

Tennessee

## 16. Informant

Address

2540  
Montrovia, Maryland

## 17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

## Cemetery or crematory

Baptist Cem.

## Location

Lisbon Md.

## 18. Funeral director

J. B. Beall, Inc.

## Address

Damascus Md.

## 19.

(Date rec'd by registrar)

19 48Lella V. Baxley  
Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH May 18, 1948 at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

February 2519 47to May 1819 48and that I last saw him alive on May 13 19 48Immediate cause of death Tuberculosis of lungs

## DURATION

10 years.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, publc place (where?)

Means of injury

Injured at work?

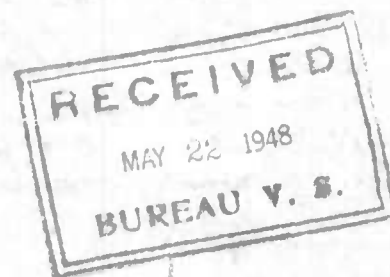
23. SIGNATURE

James P. Kern M.D.

M. D. or other

Address

Damascus Md.Date signed 5/18/48



Evidence for change of MARYLAND STATE DEPARTMENT OF HEALTH

birth date shown on:

2411 N. Charles St., Baltimore

FILM No. G 116 JUL 16 1948 CERTIFICATE OF DEATH

05200

Reg. Dist. No. 211

1. PLACE OF DEATH: **Montgomery**  
County.....**Damascus MD.**  
City or town.....**Fifteen Years**  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State **Maryland** County **Montgomery**  
City or town.....**Damascus MD.**  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....**None**

3. (a) FULL NAME  
**Mina Unglesbee**

3. (b) Social Security Number  
**None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, married, widowed, or divorced **Widowed**

6. (b) Name of husband or wife.....**William R. Unglesbee**

7. Birth date of deceased (mo., day, yr.) **Jan. 20 1871** 6. (c) If alive, give age..... years

8. AGE: Years **77** Months **4** Days **6** It less than one day..... hrs. .... min.

9. Birthplace.....**Maryland**  
(Town, county, and state)

10. Usual occupation.....**None**

11. Industry or business.....**William Burns**

12. Name.....**Maryland**

13. Birthplace.....**Rosanna A. Glaze**

14. Maiden name.....**Maryland**

15. Birthplace.....**Maudie I. Fetzner**

16. Informant.....**Damascus. MD.**

Address.....**Burial**

17. (Burial, cremation, or removal, Which?) Date thereof.....**May. 28. 1948**  
(month) (day) (year)

Cemetery or crematory.....**Damascus. MD.**

Location.....**Montgomery, MD.**

18. Funeral director.....**Roy W. Barber**

Address.....**Laytonsville, MD.**

19. **May 27 48** **della V. Burdette**  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....**May 26, 1948** at **3:00 P.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **September 18, 1943** to **May 26, 1948**

and that I last saw him alive on **May 23, 1948**

Immediate cause of death.....**Cerebral thrombosis** DURATION **6 days.**

**Arteriosclerotic cardiovascular disease.** **15 years.**

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

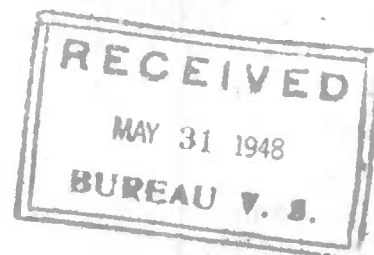
23. SIGNATURE.....**James P. Kerr M.D.** M. D. or other

Address.....**Damascus, Md.** Date signed.....**5/27/48**

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05201

Reg. Dist. No. 214  
214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## 1. PLACE OF DEATH:

County MontgomeryCity or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)Street No. 8409 Wilson Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Sarah Volk

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widow

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1862

8. AGE: Years 86 Months Days If less than one day hrs. min.

9. Birthplace Lithuania  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Baruch Lieberman

13. Birthplace Lithuania

14. Maiden name Unknown

15. Birthplace

16. Informant H. Irving Volk

Address 430 Missouri Ave NW #6

17. Burial Date thereof May 25, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Beth Shalom Cap. Bkly, Md.

Location

18. Funeral director B. Bussanek, Son

Address 3501-14 1st St Wash. D.C.

19. May 26 1948 Josephine Schaeffer

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 25, 1948 at 1:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 29, 1948, to May 25, 1948

and that I last saw her alive on May 24, 1948

Immediate cause of death Bronchopneumonia

DURATION

6 days

Due to Chronic myocarditis

generalized arteriosclerosis

Due to Senility &amp; general debility.

Other conditions Chronic glaucoma

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Sydney Leventhal, M.D.

8248 Georgia Ave. M.D. or other

Silver Spring, Md. Date signed May 25, 1948

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

LOCAL HEALTH OFFICER OF DISTRICT

DATE OF DEATH

STATE OF MASSACHUSETTS

1948 May 24

1948 May 24

1948 May 24

1948 May 24

1948 May 24

1948 May 24

1948  
86  
1862

RECEIVED  
MAY 28 1948  
BUREAU V. S.

1948 May 24

1948 May 24

1948 May 24

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 212

### 1. PLACE OF DEATH:

County Montgomery

City or town Bond  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Montgomery

City or town Bond  
(If outside city or town limits, write RURAL and give nearest town)

Street No. Rural  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Emma Frances Wade

### 3. (b) Social Security Number

#### 4. Sex

female

#### 5. Color or race

white

#### 6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife Crawford F. Wade

7. Birth date of deceased (mo., day, yr.) August - 4 - 1902

6. (c) If alive, give age 45 years

8. AGE: Years 45 Months 9 Days 15 If less than one day  
hrs. min.

9. Birthplace Lucketta, Va.  
(Town, county, and state)

10. Usual occupation housewife

11. Industry or business home

12. Name Robert E. Hewton

13. Birthplace London Co., Va.

14. Maiden name Mary Virginia Porter

15. Birthplace London Co., Va.

16. Informant Ruth Compher

Address 416 W. Patrick St., Frederick, Md.

17. Burial Date thereof 5-22-48  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Monocacy

Location Bealeville, Md.

18. Funeral director Wm. B. Hilton

Address Barnesville, Md.

19. May 21, 1948 Mrs. C. C. Hilton  
(Date rec'd by registrar) (Signature)

By Mrs. C. C. Hilton Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH May - 19 - 1948 at 10<sup>35</sup> P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July - 1946 to May - 19 - 1948

and that I last saw him alive on May - 15 - 1948

Immediate cause of death cancer of Uterus

#### DURATION

2 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William C. Miller, M.D. M. D. or other

Address Gaithersburg, Md. Date signed 5/19/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 28 1948

BUREAU V. S.

3132

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

05203

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 day  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 1 day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 442 Newton Place, N. W.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war WW II

## 3. (a) FULL NAME

Fred WADE

## 3. (b) Social Security Number

4. Sex male 5. Color or race Col. 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Mrs. Marjorie Helen Wade  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) February 26, 1918  
 8. AGE: Years 30 Months 3 Days 3 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace S. C.  
 (Town, county, and state)  
 10. Usual occupation Porter  
 11. Industry or business \_\_\_\_\_  
 12. Name WILLIAMS, Clarence dec  
 13. Birthplace S.C.  
 14. Maiden name BYRD, Hattie  
 15. Birthplace S.C.

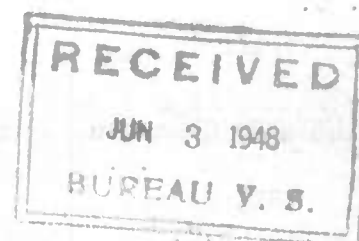
16. Informant wife: Mrs. Marjorie H. Wade  
 Address 442 Newton Pl., N.W., Wash., D.C.  
 17. burial Date thereof 6-2-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Arlington National Cemetery  
 Location Arlington, Virginia  
 18. Funeral director W. Ernest Jarvis  
 Address 1432 U St., NW, Wash. D.C.  
 19. 5-29 48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 29 May 19 48 at 12:05 A  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 28 May 19 48 to 29 May 19 48  
 and that I last saw him alive on 29 May 19 48  
 Immediate cause of death Pulmonary embolism (massive)  
 DUE TO Myocardial infarction 5 yrs. prior disease.  
 DUE TO \_\_\_\_\_  
 Other conditions Bronchopneumonia  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results Same as above.  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury ICE Billman Injured at work? 10/10  
 23. SIGNATURE D. E. BILLMAN, Lt. JG MC USN  
 M. D. or other \_\_\_\_\_  
 Address USNH Bethesda, Md. Date signed 5-29-48



*Handwritten signature or initials*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

05204

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Kensington  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 25 years  
 Hospital, institution, or street address where death occurred:  
7 Connecticut Ave.  
 How long in hospital or institution? —

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Kensington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 7 Connecticut Ave.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war —

## 3. (a) FULL NAME

William Frederick Walker

## 3. (b) Social Security Number

—

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Jeannette E. Walker  
 7. Birth date of deceased (mo., day, yr.) May 19, 1877 6.(c) If alive, give age 47 years  
 8. AGE: Years 70 Months 11 Days 29 If less than one day — hrs. — min.

9. Birthplace Washington, D.C.  
 (Town, county, and state)  
 10. Usual occupation Sheet Metal Worker  
 11. Industry or business Retired past 7 years  
 12. Name John Walker  
 13. Birthplace Washington, D.C.  
 14. Maiden name Louisa Winter  
 15. Birthplace Washington, D.C.

16. Informant Mrs. Wm. B. Walker  
 Address 7 Conn. Ave. Kensington, Md.

17. Burial Burial Date thereof May 21, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Rockville Union Cemetery  
 Location Rockville, Maryland

18. Funeral director W. Paul Gumpfrey  
 Address Bethesda 14, Maryland

19. 5/24 19 48 W. E. Jones  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 19 48 at 6:24 p. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1 19 39 to May 18 19 48  
 and that I last saw him alive on May 18 19 48

Immediate cause of death Uremia DURATION 1 wk.  
 Due to Cardio-vascular-renal disease over 10 yrs.  
 Due to —  
 Other conditions Arthritis deformans 9 yrs.  
 (Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results —  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;  
 Accident, suicide, or homicide — Date of —  
 Where did injury occur? — (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) —  
 Means of injury — Injured at work? —

23. SIGNATURE Katharine R. Chapman MD  
20 West Baltimore St. M. D. or other  
Kensington, Md. Date signed 5/18/48



RECEIVED  
MAY 28 1948  
BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH

County MontgomeryCity or town Bethesda 14  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Margaret J. Walters

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

April 19, 1872

6. (c) If alive, give age..... years

8. AGE:

46014hrs.min.

9. Birthplace

Philadelphia Pa.  
(Town, county, and state)

10. Usual occupation

housekeeper

11. Industry or business

MOTHER FATHER

12. Name

Nixon

13. Birthplace

Ireland

14. Maiden name

Unknown

15. Birthplace

?

16. Informant

Price J. Walters

Address

5506 - Charles St. Bethesda 14

17.

Burial  
(Burial, cremation, or removal. Which?)

Date thereof

May 6, 1948  
(month) (day) (year)

Cemetery or crematory

Cedar Hill Cemetery

Location

Sutland Md.

18. Funeral director

Wm. J. Nalley

Address

5200 - R.F. Ave. Mt. Rainier, Md.

19.

5.3.48  
(Date rec'd by registrar)

19.

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town.....  
(If outside city or town limits, write RURAL and give nearest town)Street No. 5506 - Charles St.

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1948 at 9:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 1 1948 to May 3 1948and that I last saw him alive on May 3 1948Immediate cause of death Cancer of Cervixof Head of Cervix

DURATION

1 yr.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of Cervixwith metastases to liver Date of op. May 9, 1948

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address 3921 Engoman St. NW Date signed May 3, 1948

MARGIN RESERVED FOR BINDING

VS 415 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

Jones

512 Maple Ridge

RECEIVED

MAY 6 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 218

05206

94a

### 1. PLACE OF DEATH

County Montgomery  
City or town Germanstown Rural  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 1/2 yrs  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montg  
City or town Germanstown Rural  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. (If rural, give LOCATION)  
2(a) If veteran, name war Spanish - World war 1 and 2

### 3. (a) FULL NAME

Park Milburn Ward

### 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male white married

6. (b) Name of husband or wife Evelyn Claudia Ward

7. Birth date of deceased (mo., day, yr.) Sept 16 1883

8. AGE: Years Months Days If less than one day  
64 7 21 hrs. min.

9. Birthplace Maryland  
(Town, county, and state)

10. Usual occupation Captain, Commander

11. Industry or business Mechanic Marine

12. Name Frank Ward

13. Birthplace Md - Adams

14. Maiden name Lois - Adams

15. Birthplace and -

16. Informant Evelyn C Ward

Address Germanstown Md R-1

17. Burial Date thereof 5/12/48

(Burial, cremation, or removal Which?) (month) (day) (year)

Cemetery or crematory Arlington National Cemetery

Location Arlington Va

18. Funeral director Emory B Galtner

Address Faithersburg Md

19. May 9 1948 Abuda I Cooke

(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1948 at 8:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Def med exam case

and that I last saw him alive on 19

Immediate cause of death

Coronary occlusion third  
stroke

Due to

Due to

Other conditions arterio-sclerosis 2 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Mens of injury Injured at work?

23. SIGNATURE Frank J. Bruchant M.D.

Def med exam M. D. or other

Address Faithersburg Md Date signed 5-7-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 12 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The carriage is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 05207216

## 1. PLACE OF DEATH:

County Montgomery Co.City or town Brookmont, Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 22 YRS.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery Co.City or town Brookmont, Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 6012 - Ridge Drive  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Benjamin Franklin Watkins

## 3. (b) Social Security Number

4. Sex Male5. Color or race White6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife IDR - MOORE - WATKINS

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 31. 18728. AGE: Years 75 Months 4 Days 27 If less than one day8. AGE: 75 4 27 hrs. min.9. Birthplace Kemper County - Miss.  
(Town, county, and state)10. Usual occupation BUILDER - RETIRED

11. Industry or business

12. Name George Washington13. Birthplace Miss.14. Maiden name Caroline Knopp15. Birthplace Miss16. Informant Odehke W. BROWNAddress 6012 Ridge Drive Brookmont17. BURIAL Date thereof May-29-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory NATH. MEMORIAL PARKLocation Falls Church Va.18. Funeral director W. W. Chambers Co.Address 3072 - M - St. N. W.19. 5/27 1948 W. E. Jones  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1948 at 11:43 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1946 to May 27 1948and that I last saw him alive on May 27 1948Immediate cause of death Coronary ThrombosisDue to Arterio-sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Grace G. Purse M.D.

1801 - Eye St NW

Date signed May 27, 1948

RECEIVED

JUN 3 1948

BUREAU V. S.